INFLUENCE OF DEVOLUTION ON HEALTHCARE SERVICE DELIVERY IN BUSIA COUNTY, KENYA

BY

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DECLARATION

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DEDICATION

This work is dedicated to my Loving mother Christine Chemei and my dear brothers Peter Chessetto and Simon Chessetto as well as My beloved wife Damaris Olinga.

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ABSTRACT

The constitution of Kenya (2010) introduced a devolved system of governance which entrenches health as a right for every citizen, to the highest attainable standard. Further, it also designates the health services functions of the national government and County Government and principles under which such services should be provided. Following the first general elections under the constitution of Kenya (2010) and creation of County Governments, the need to address the administration, planning and management of health services in response to the changes became necessary. Notably, several Counties have been bedevilled with monumental challenges ranging from strikes, corruption and delayed salaries resulting to poor service delivery among others. The research general objective was to assess the influence of devolution on healthcare quality service provision in Busia County. The specific objectives were: to assess the influence of resource allocation, health leadership, organizational structure and health workforce competence on healthcare quality service delivery in Busia County. The study employed descriptive research design targeting healthcare workers and other County Government officials. Questionnaires and interview schedules were used in collecting Primary data from target population; Doctors, Nurses, Clinical officers, Pharmacists, Laboratory technicians, Hospital administrators, Medical superintendents and County health officials; County assembly health committee, health Director, Chief Officer for health and the County Executive Committee member for health. The sample size comprised of 200 individuals from the target population arrived at by consulting Yamane Taro formula. Descriptive and inferential statistics was utilized in data analysis and study findings were presented in form of frequency tables. The summary of the findings show's that resource allocation had to a great extent helped in the healthcare quality service delivery in Busia County. Similarly, health leadership, workforce competence and organizational structure were significantly effective in influencing healthcare quality service delivery in Busia County. The study concludes that the availability of resources have had a significant provision of quality health services in Busia County. The study thus recommends that: The county government management should ensure that they engage in proactive and effective resource allocation mechanisms like financing, technology and human resource to improve provision of quality healthcare services. The allocations should be deliberate with significant resources given to critical service delivery areas. The County Government management should use transformational leadership in their health leadership style. The County Government management should integrate a decentralized structure. The study has found that strongly decentralized structures perform well in several contexts, notably in service delivery and implementation of strategy. The management should also ensure that the workers are results oriented in a bid to improve the Healthcare workforce competence, and consequently improve the provision of quality healthcare services. Finally, the government through the Ministry of Devolution and Planning should improve on its devolution policy to further fortify health provision in the counties.

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OPERATIONAL DEFINITION OF TERMS

Decentralisation - refers to the process of transferring power or decision making and resources from the central government to lower units of government such as regions, districts and municipalities. It involves the transfer of responsibility for planning, management, resource mobilisation, and allocation from the central government to field units of the central government agencies, subordinate units or lower levels of government, semi-autonomous public authorities or corporations, regional or functional authorities. This takes different forms:

Devolution - refers to the transfer of political power, administrative authority and resources to lower levels of governments with locally elected politicians. The devolved units have the autonomy with clearly demarked areas of decision making through constitutional rights (anchored in the constitution).

Health - is defined as general mental, physical, and social well-being. In this definition, the environment in which people live, including access to nutritious food, safe water, sanitation, education and social cohesion also determines health.

Primary healthcare – is defined as essential health care; based on practical, scientifically sound and socially acceptable method and technology; universally accessible to all in the community through their full participation; at an affordable cost; and geared towards self-reliance and self-determination (WHO 1978).

Healthcare services – refers to the prevention and management of disease, illness, injury and other physical and mental impairments in individuals delivered by healthcare

professionals through the healthcare system; they can either be routine health services or emergency health services (KHP 2014-2030).

Health infrastructure – relates to all the physical infrastructure, non-medical equipment, transport and technology infrastructure required for delivery of services (GoK, 2014).

Healthcare human resources – refers to the workforce that delivers the defined healthcare services. The workforce includes all those whose prime responsibility is the provision of healthcare services, irrespective of their organizational base (public or private) (GoK, 2014)

LIST OF ABBREVIATIONS

CGA – County Government Act

CIC – Constitution Implementation Commission

CIDP – County integrated development plan

CoK– Constitution of Kenya

CRA – Commission on Revenue Allocation

GHS– Ghana Health Service

GoK– Government of Kenya

IMF – International Monetary Fund

KDHS – Kenya Demographic Health Survey

KHPF– Kenya Health Policy Framework

LAO– Local Administrative Organizations

MDG– Millennium Development Goals

NARC – National Rainbow Coalition

TA – Transition Authority

WHO – World Health Organization

SPSS – Statistical Package for Social Sciences

CHAPTER ONE

INTRODUCTION

1.0 Introduction

This chapter provides a background for this research study. It highlights on the devolution process and its effects on the healthcare sector. The research looked at devolution in relation to healthcare service provision beginning from developed countries and narrowing down to developing countries and finally the study area. This research will also provide an explanation of the problem statement, objectives and the limitation of the study.

1.1 Background of the Study

World Bank study showed that 63 developing countries have initiated reforms aimed at transferring political power to local units of government. The main goal of such reforms is to enhance equity, increase efficiency and ensure more participation and responsiveness of government to citizens. However, reviewed literature shows mixed results with regard to the benefits and challenges of decentralization, especially in the health sector World Bank,(2008).

Primary healthcare services in many developing countries are facing different challenges, even with the fact that there is an enormous progress in health globally. Many studies have documented that decentralization could be useful in supporting and developing health services closer to citizens. Cheema and Rondinelli (1983) for example, notes that, the study of decentralization has gained momentum as a central issue in the field of public administration because of the efforts put in place to try and respond to the current needs of the public, especially in the areas of policy, choices and in creating a more democratic and

responsible government. Health sector is not exceptional however; it is actually a critical area in ensuring that there is development in a country. A healthy population is more likely to concentrate on development issues than one being afflicted by diseases and ill health.

According to Falleti, (2010), decentralization is categorized into four types; political, administrative, fiscal, and market decentralization. Rondinelli, (1981) on the other hand, argues that administrative decentralization seeks to redistribute authority, responsibility and financial resources in providing public services among different levels of government. Decentralization is seen as a solution to development problems and that is why many states work hard towards implementing this system of governance. For instance, the systems that were used in governance by many developing countries borrowed a lot from their colonizers and were majorly centralized in accordance with the laws of the countries they come from.

A study of health sector in countries like Scotland, Wales and Northern Ireland shows that, policy makers agree on core objectives that should guide the performance across the region. Some of the common objectives include; universal health access for citizens, effective care for better health outcomes, efficient use of resources, high-quality services and responsiveness to patient concerns. However, this seems to be only theoretical and abstract but when an attempt to implement the same is made; it turns up into divergent, occasionally contradictory approach. This is not unique to the European health sector; it happens anywhere in the world. The main reason can be the inherent advantages that are present in every system in relation to the context and policy priorities (Elias et al…, 2007). The logic of decentralization is based on an intrinsically powerful idea. It is, simply stated,

that smaller organizations, properly structured and steered, are inherently more agile and accountable than are larger organizations.

In the South-East Asia Region, although there are no devolved systems of governance, steps have been taken to delegate administrative and financial authority to vertical and horizontal differentiated health-related institutions in the form of district, region, hospital boards, community level health units to help promote decentralization of health services. However, the extent and sufficiency of delegation can be questioned. India for example is a federal state, with a well-developed healthcare system which has seen the country lead in the region in terms of its ability to deal with complex issues.

Several Latin American countries have had the health decentralization policy in their agenda for the last two decades. According to Kim, (2001) efforts to implement decentralization have not been easy, he describes the situation as being "patchy and halting", which reflects the contradictory expectations and interests that have marred the process. Latin American countries can be divided in two categories; those countries with a three-tier government system composed of the central government, states, departments or provinces, and municipalities for example Brazil, Mexico, Argentina, Colombia, among others. The second category consists of the smaller countries with two-tier government systems composed of the central government and municipalities among them Costa Rica and Panama in Central America.

Kim, (2001) further explains that, "decentralization of health services in Latin America countries is implemented through devolution and delegation of subsets of key functions and responsibilities to different government levels rather than through decentralization of the whole set of functions to a sub-national government". He then summarizes that the

approach seems to suggest that the decentralization process was prompted by other reasons other than being an appropriate way to achieve efficiency in the health sector. In effect, the decentralization of subsets of inputs or functions coupled with a lack of clarity as to the structure of accountability will possibly fail to have improved efficiency. In most cases, except Brazil and Argentina, personnel administration remains at the central level, as a result of negotiations with workers' unions. This includes salary scales, benefits, promotions, hiring, firing, and sanctioning. This means limited personnel and administrative matters like permits and promotions have been delegated to states or municipalities.

South Africa has also been undergoing major changes related to decentralization. The health sector has been establishing a district-based primary healthcare system. This is a significant departure from the past and the main goal here is to create a unified but decentralized national health system based on the District Health System (DHS) model. One of the main reasons for this is the belief that this system is more appropriate for the delivery of Primary Healthcare (PHC). In addition, the decision to decentralize the delivery of healthcare is consistent with the overall policy to decentralize Government. According to Ndavi et al…, (2009), "ADHS based on PHC is a more or less self-contained segment of the national health system. It comprises of a well-defined population living within a clearly delineated administrative and geographic area. It includes all the relevant healthcare activities in the area, whether governmental or otherwise" .According to the government of South Africa's White paper of (1997) states the roles of District Health System and the National healthcare system is taking care of the overall management and control of their health budgets and for a full range of comprehensive primary healthcare services within

their areas of jurisdiction. It also directs that effective referral networks and systems be ensured through co-operation with the other health districts.

In Ghana, decentralization has played a pivotal role in government policy ever since the country became independent. Following the 1993 Local Government Act, the District Assemblies' responsibilities were limited to activities in the field of public health for example the health promotion and disease surveillance and control. The Ministry of Health has delegated the responsibility of managing its facilities to an autonomous entity created in 1996, the Ghana Health Service (GHS). The Ghana Health Service is responsible for managing and operating most of the country's facilities and offices. The Ghana Health Service subsequently evolved into a more de-concentrated structure with regional and district health offices. Although both structures are based on the principle of delegation and de-concentration at a district level, there is not one single authority for coordination of health service delivery on a district level. The situation in Ghana is a bit more complicated. On one side, there is the Ghana Health Service to which the responsibility of managing health facilities has been delegated. The Ghana Health Service organized itself into regional and district offices. On the other side, there is the District Assembly that acts as devolved entity (Crook 2003).

During the 1990s, the government of Tanzania introduced decentralization through devolution approach by transferring power, functions and authority from the center to the Local Government Authorities (LGAs) to improve the delivery of public goods and services including health services. Additionally, the main institutions for local level delivery of basic services are essentially with the Local Government Authorities, in rural areas, at district and village level. The decisive step towards empowering the Local

Government in that regard was taken in June 1996, when the Prime Minister announced the government's decision to restructure and downsize regional administration with the objective of making local government more efficient and effective. The government responded to a deteriorating state of the healthcare system in the 1980s, through the Ministry of Health and Social Welfare (MoHSW) which received enormous support from major development partners. The country initiated a Health Sector Reform (HSR) in the early 1990s with the aim of improving the health of the Tanzanian population in general, and especially women and children, through improvement of the healthcare service delivery system. The country came up with a long-term development framework laid down in the Vision 2025 (1998). The government formulated a Program of Work (1999 – 2002) and subsequently the Health Sector Strategic Plan (HSSP) (2003–2008) to guide in implementing health sector reforms (Thomas et al…, 2002).

The HSSP addresses eight strategic areas: The District health services, Secondary and tertiary hospital services, The role of the central Ministry of Health (MoH), Human Resources Development (HRD),Central support systems, Healthcare financing, Public private partnerships and the MoH-donor relationship. The health service at the district level in Tanzania is devolved to local authorities to increase their mandate in health service provision. Under the devolved arrangement, the health units, including the district hospital, provide services under the supervision of the council health service boards and HFCs. As health service provision are increasingly being decentralized, it became the duty of the councils through council health service boards, Council Health Management Teams (CHMTs), council hospital governing committees and facility committees, to ensure that health facilities and services provided are of acceptable quality. Furthermore, these

facilities have to be managed by qualified personnel according to staffing level in line with Ministry of Health and Social Welfare (MoHSW) policy guidelines and standards. Since its adoption by the government, PHC has been the cornerstone of the national health policy in Tanzania (Per et al…, 2008).

The current transition from national to county governments in Kenya is faced with problems of inconsistency, poor understanding of the system, management issues and lack of coordination between the two levels of government. At national level, challenges of devolution as depicted by the print and broadcasting Medias having emerged in form of poor management, resource distribution, ethnicity fears, poor working conditions and delayed salaries among other factors. Reports of health workers resigning due to the above issues have been rampant and so are strikes and strike threats.

It can be argued that no healthcare system is perfect. Globally, the healthcare sector is facing enormous, challenges around both development and maintenance. In Africa, the sector is undergoing major policy, system, and infrastructural changes. Systems across the globe have and are experimenting with old as well as new approaches to "fix" their health systems. In efforts to improve access, improve service delivery, bend the cost curve, increase accountability, and improve responsiveness, to mention a few.

Decentralization of health system structure and management has been and continues to be a key issue for many countries in the achievement of health for all, and development of primary health care. Decentralization has been defined and understood in multiple ways. Although typically defined in public planning, management and decision-making as the transfer of authority and power from higher to lower levels of government or from national to sub national levels (Rondinelli 1983; Collins and Green 1994; Mills 1994). In 1994, the

Government of Kenya (GOK) approved the Kenya Health Policy Framework (KHPF) as a blueprint for developing and managing health services. It spells out the long-term strategic imperatives and the agenda for Kenya's health sector. The Ministry of Health (MOH) developed the Kenya Health Policy Framework Implementation Action Plan and established the Health Sector Reform Secretariat (HSRS) in 1996 under a Ministerial Reform Committee (MRC) in 1997 to spearhead and oversee the implementation process.

A rationalization program within the MOH was also initiated and it aimed at responding to the following constraints: decline in health sector expenditure, inefficient utilization of resources, centralized decision making, inequitable management information systems, outdated health laws, inadequate management skills at the district level, worsening poverty levels, increasing burden of disease, and rapid population growth.

In August 2010, Kenya adopted a new constitution that introduced a new governance framework with a national government and 47 counties. Before 2010, the system of government that was in place was so centralised and therefore the devolution introduced by the new constitution is seen as a complete departure from the past regime.

The highly centralized government system previously in place led to the weak, unresponsive, inefficient, and inequitable distribution of health services in the country (Ndavi et al., 2009). It is expected that a devolved health system will improve efficiency, stimulate innovation, improve access to and equity of services, and promote accountability and transparency in service delivery (Bossert, 1998). However, the complexity of Kenya's devolution framework has generated a new concern that services could be disrupted if the transition is managed poorly.

Under the new framework, responsibility for health service delivery is assigned to the counties while policy, national referral hospitals, and capacity building are the national government's responsibility (Constitution of Kenya, 2010). The framework for the transfer of these functions is in the Transition to Devolved Government Act, 2012. The health service delivery function was formally transferred to counties on August 9, 2013, and one-third of the total devolved budget of Kenya Shillings 210 billion was earmarked for health in the 2013/2014 budget following the transfer.

Following the general elections in March 2013, each county had the task of establishing a "blueprint for change" for its health system. In the new Constitution of Kenya, 2010, fourth schedule in article 185 ,186 and 187 , it establishes the distribution of functions between the National and the County governments where the National government handles National referral health facilities and Health policy, while County governments handle County health services, including, in particular, county health facilities and pharmacies; ambulance services; promotion of primary health care; licensing and control of undertakings that sell food to the public. Legal notice No. 137 of 2013 indicates all the health services were transferred to the counties after the Counties made formal application (Constitution of Kenya, 2010).

The importance of the health sector's contribution to economic growth and poverty reduction is recognized globally. Three of the eight Millennium Development Goals (MDGs) of reducing child mortality, improving maternal health and combating HIV/AIDS, malaria and other diseases, refer directly to health yet Kenya is still far from achieving them. The Abuja Declaration of the year 2001 requires countries to earmark 15 per cent of their national budgets for the health sector, a target that is yet to be met by the Government

of Kenya. A 2006 report by the World Health Organization (WHO) indicates that insufficient health budgets in low income countries combined with health problems such as HIV/AIDS, have led to an acute shortage of health workers. Many low income countries experience shortage of drugs and medical supplies, poorly remunerated health personnel or non-payment of health workers, poor quality of care, and inequitable healthcare services (WHO, 2002).

The Jubilee government has corroborated the Sustainable Development Goal Pillar of ensuring healthy lives and promoting well-being for all ages by promoting Affordable Health Care. This policy provides universal healthcare for all, the government intends to undertake major policy and administrative reforms in the medical sector, pursue and facilitate synergies and collaboration between NHIF and private sector to provide health services as well as instituting systems and mechanisms that will help reduce costs of health care. Also the county government of Busia plans to promote and provide universal healthcare to her residents through uptake of health insurance, putting up health infrastructure and human resource development in the health sector especially the establishment of a special women's hospital.

Corruption has become both a cause and effect with the result being the deterioration of general health services as well as degradation of health systems in developing countries (World Bank, 2004). Kenya sits in an advantageous position. Other countries have implemented devolution successfully providing Kenya a platform to learn from and make devolution of healthcare services work. Despite that, the health sector is still facing a lot of challenges like strikes and threats to strikes by county health workers, resigning of health workers especially doctors, poor working conditions and delayed salaries. In some cases,

this can be due to low budget allocation and job security fears by healthcare workers. Achieving integrative healthcare services is a key policy objective of Kenyan devolved governance and is intended to reduce the frustration, delay, the inefficiency, and the gaps that existed in the centralized health system management.

The new constitution ushered in devolved governance which was a manifestation of the people's desire for change, government accountability, and democracy, the concept of devolution of political and economic power to 47 newly-created Counties (CoK, 2010). Devolution usually transfers responsibilities for services to counties that elect their own governors and raise their own revenues, and have independent authority to make investment decisions. In a devolved system, local governments have clear and legally recognized geographical boundaries over which they exercise authority and within which they perform public functions.

The success of decentralization depends more on the consistency between objectives, design and implementation of the process. Article 174 of the Kenyan Constitution clearly articulates the rationale behind devolution as, among other reasons, self-governance, economic development and equitable sharing of national and local resources. The Kenyan government devolved healthcare in order to promote access to health services throughout Kenya, to address discrimination of the "low potential areas". Urban areas have had better health services than rural areas, to address problems of bureaucracy in matters of health service provision especially procurement related problems, to promote efficiency in the delivery of health services and to address problems of low quality of health services. Devolution in Kenya now allows County governments the space to design innovative models that suit the terrain of their unique health sector needs, sufficient scope to

determine their health system priorities, and the authority to make autonomous decisions on subsector resource allocation and expenditure. On the other hand, devolving the health function presents equity, institutional and resource challenges are dealt with to assure effective and sustainable health care. It requires harmony in health sector planning, budgeting, Monitoring and Evaluation at National and County levels.

1.4 Statement of the Problem

Devolution came with fears of disruption of services that are largely linked with concerns about the counties being ready to deliver services. In the political arena, devolution can take on numerous dimensions. There is, first, the structural issue: how devolution influences and is influenced by existing institutions of government in a given country. A second dimension reflects where those institutions come from, e.g. the values that led to and sustain a particular set of governmental institutions. Together, these factors are sometimes referred to as the "context" within which devolution is undertaken.

Rather differently, scholars have insisted on the importance of adding a political economy perspective to assessments of devolution. For example, Wolman (1990) argued that, since intergovernmental decentralization is often driven as much as by political and constitutional necessities as by economics, apolitical economic perspective is required. Mackintosh (1999) also has advocated a political economy approach to decentralization. According to Mackintosh devolution leads to increased autonomy in local resource mobilization and utilization, an enhanced bottom-up planning approach, increased health workers' accountability and reduction of bureaucratic procedures in decision making. In Kenya the Transition Authority (TA) set specific timelines and criteria for the assessment of County preparedness to take up devolved functions. Further, political pressure from the

newly elected county governments resulted to a bulk transfer of functions, irrespective of the Counties level of preparedness.

According to scholars like McCollum et al…, (2016) the decision space created by devolution presents the opportunity for counties to address disparities in health sector, by planning and budgeting to adapt the new community health strategy according to local county context and disease burden. According to Rumbold *et al…,* (2017) policy makers should balance both the need to set priorities fairly and efficiently with safeguarding citizens' right to health. But despite devolving health, health staff unrest has been witnessed since the advent of County governance affecting service delivery and posing health risks to thousands of Busia County residents. There is limited data on devolution of healthcare in Kenya and very little has been done to assess the implementation of devolved healthcare system in Kenya and its influence to devolved healthcare service delivery in Kenya. This research therefore sought to find out the influence of devolution on healthcare service delivery in Busia County, Kenya.

1.5 Research Objectives

The general objective was to assess the influence of devolution on healthcare service delivery in Busia County. The specific objectives of this work were to:

1. Investigate the impact of resource allocation on healthcare quality service delivery in Busia County.
2. Examine how healthcare leadership influence healthcare quality service delivery in Busia County.
3. Explain the influence of organizational structure on healthcare quality service delivery in Busia County.

4. Assess how healthcare workers competence influence healthcare quality service delivery in Busia County.

1.6 RESEARCH QUESTIONS

1. Does resource allocation have a significant influence on devolved healthcare quality service delivery in Busia County?

2. How does healthcare leadership influence healthcare quality service delivery in Busia County?

3. What role does Organizational structure have in influencing healthcare quality service delivery in Busia County?

4. What is the influence of healthcare workers competence on healthcare quality service delivery in Busia County?

1.7 Significance of the Study

The study will inform policy formulation regarding resource allocation and management of healthcare workforce in order to attain the highest standard of health as indicated by the Kenya health policy framework 2014 – 2030. The study shall establish the implications devolution has brought about in Kenya with a special focus to Busia County, so as to be able to analyse and recommend best practices for adoption in the improvement of health sector services. The study also intended to provide information on areas for further research since devolution is a new concept in Kenya and despite other countries having devolved healthcare, every country has its own unique challenges and opportunities. The study will help enrich the scanty literature on Devolution of Healthcare in Kenya and be a reference

point with more accurate data. If devolution in Kenya has to succeed then more strategies should be tailored around empirical knowledge on the resources, problems and geographical location in managing various sectors.

1.8 Scope of the Study

The research focused on health facilities in Busia County which were evenly selected across all the seven sub counties. The respondents were also selected across all health departments, the County Assembly Health Committee and the Management of the Department of Health in the County (Health Director, Chief Officer, and County Executive Committee Member for health).

1.9 Summary of the Chapter

This chapter discussed the background of the study, statement of the problem, research objectives, significance, scope and limitations of the study. The next chapter will be reviewing literature thematically.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter looks at the various scholars' arguments in relation to service delivery on healthcare sector after transition from Central to County Governments. The chapter is organized thematically and this follows the extraction of sub-themes from the objectives of the study.

The study of decentralization is one of the most venerable issues in the field of public administration. It is also one of the most vigorous policy choices in creating a more democratic and responsible government. It is not surprising, therefore, that there is a large and growing theoretical literature on decentralization (Cheema and Rondinelli 1983). Decentralisation therefore refers to the process of transferring power or decision making and resources from the Central Government to lower units of government such as regions, districts and municipalities. It involves the transfer of responsibility for planning, management, resource mobilisation, and allocation from the central government to field units of the central government agencies, subordinate units or lower levels of government, semi-autonomous public authorities or corporations, regional or functional authorities.

As broadly understood, decentralization materializes into four types of political, administrative, fiscal, and market decentralization. According to Rondinelli (1981), administrative decentralization seeks to redistribute authority, responsibility and financial resources in providing public services among different levels of government.

Opinion surveys reveal that the overwhelming majority of citizens, trust local governments as compared to a centralized government, and that sectorial allocation are in line with community preferences (Gershberg, 1998). Among the factors cited for this kind of preference of decentralization over the centralised system is the reduction in cartelistic practices through the elimination of opportunities for elected officials to misuse funds, and the regular use of opinion surveys through which leaders can get a better match between development programs and community preferences.

Kenya's struggle for constitutional reforms has its roots in the desire to correct deficiencies in its post-independence governance framework which was premised upon the highly centralized system started in the colonial days. The main objective of this struggle has been the restoration of power to the people to manage their affairs, particularly, in matters of local development. The post-independence governance framework was characterized by poor governance as evidenced by corruption, ethnic conflict, insecurity, political uncertainty and poverty. Some of the negative outcomes include the alienation of large portions of society from the mainstream economy; wasteful public investments; massive poverty and ethnic animosity; and cut-throat political competition and intolerance (Gershberg, 1998).

The 2007 post-election crisis was largely due to weaknesses in key institutions of governance including the Constitutional framework, Judiciary, Police, Executive, the Electoral system, and Parliament. The weaknesses of these institutions can be traced back to the recentralization of power in the executive through post-independence constitutional and legal amendments in 1966 which struck out the regional governments and the 1982 amendments that made Kenya a de-jure one party state. This resulted in monopolization of

power as opposition political parties, were initially frustrated and eventually outlawed. Small political cum-economic elite that accumulated both political control and economic wealth to protect the centralized system captured state power. Democratic advancement was stifled as the governance of the country drifted from constitutional rule to personal rule. The national goals of fighting poverty disease and ignorance, which had been set at independence, were distorted.

The Constitutional Commissions have not been decisive in supporting the faithful roll out of devolution and this is of concern. Implementing Functions Transferred to Counties, Services and resources, were devolved rapidly. However, a number of questions that can be raised concerning the Kenyan health system remain unanswered. Surprisingly, there are significant capacity problems common in the county political and management structures. When resources were devolved, few counties possessed the administrative capability to absorb the available funding or plan for its use. Although the national government was concerned about these capacity gaps, it had not outlined training and mentoring plans for the counties, as it expected to use the full three-year transition period originally allowed by law (Bennett, 1990).

The main challenges reported across counties includes; Lack of a functional analysis which resulted in failure to comprehensively establish what each function entails; Insufficient infrastructure; Lack/limited skills in specialized areas such as health services, planning, road construction and Funding gaps as a result of inadequate funds to finance all functions, release of funds all of the above problems end up hampering the implementation process. The other bunch of unresolved problems are, tensions between County and National government staff, and Public participation , apathy from members of the public.

The constitution of Kenya 2010 guarantees health for all Kenyans. In Article 26 the constitution states that every person has the right to life. Article 42 states that, every person has the right to a clean and healthy environment. Article 43 (1, a) every person has the right to the highest attainable standard of health, which includes the right to healthcare services, including reproductive health care. The same Article 43 (1, c) gives every child the right to basic nutrition, shelter and health care. Article 56 (e) of the constitution says that the State shall put in place affirmative action programmes designed to ensure that minorities and marginalised groups have reasonable access to water, health services and infrastructure (COK, 2010).

Devolution of the health system has had several aims that include promoting access to health services throughout Kenya, to address discrimination of the "low potential areas", Urban areas have had better health services than rural area, to address problems of bureaucracy in matters of health service provision especially procurement related problems, to promote efficiency in the delivery of health services and address problems of low quality of health services.

2.2 Resource Allocation on Healthcare Service Delivery

Financing decentralization according to (Saltman and Bankauskaite, 2006) is termed as "fiscal federalism" even in unitary parliamentary states and can be defined as the division of taxing and expenditure functions among different levels of government. This has been a hotly debated issue in many western European countries. There are also a number of controversies in economic theory regarding the best way to finance intergovernmental levels. The most intense discussions refer to the rights of local governments to levy taxes for instance fiscal decentralization. Oates's theorem (1972), for example, contends that it

will always be more efficient for local government to provide services within its respective jurisdictions than for a central government to provide those services across several local authorities. In many countries, central governments have been the main source of revenue for devolved units of governments. This situation according to Oates (1972), may result in several dilemmas because the central contributions contradict the notion of local accountability and the high levels of decentralization will necessarily create high levels of "grant dependency", particularly when there are unconditional grants from higher levels of government that do not limit the discretion of the lower-level recipient. In Kenya and more so in Busia County, public healthcare as a function have been devolved and with its devolution, healthcare workers are not best taken care of as when they were under central government as demonstrated by their regular strikes and demonstrations for better working conditions.

A notably different impact can be discerned in the post-communist countries of central and Eastern Europe, which sought to decentralize the financing of their health systems in addition to the provision of services. Along with economic difficulties, poor planning of decentralization resulted in negative outcomes in some countries. In the Russian Federation and Ukraine, for example, multilayered healthcare systems now have fragmented responsibilities. Decentralization of financing in Ukraine led to increasing inequalities between wealthy and poor areas. Latvia experienced significant problems when funding for healthcare services through local government budgets resulted in widely differing amounts of health expenditure per inhabitant between regions (De Roo et al.., 2004).

According to (De Roo et al.., 2004) there are questions which we should ask ourselves, how well decentralization can address newly emerging healthcare needs and how can

decentralization improve access to health services in our societies. This study finds the above questions relevant to the quest in this research in exploring the influence of devolution on healthcare service delivery in Busia County and in Kenya at large. Several countries have employed decentralization strategies to address their long-term care needs, mainly through the consolidation of administrative functions. In predominantly tax-funded Nordic countries (Denmark, Norway and Sweden), responsibility for planning, organizing, delivering and financing long term care has been decentralized to municipal level. The aim of this strategy has been to achieve closer inter-sectorial cooperation between social and home care services through allocation of responsibility to the lowest level of governance. The largest part of social services in Denmark and Sweden is financed by local taxes while in the Netherlands, a predominantly social health insurance country, responsibility for long-term care has been pooled through regional "care offices" in order to simplify programme administration at the level closest to care recipients and to ensure appropriate resources to meet regional needs (De Roo et al.., 2004).

Furthermore, the main principle of public finance argues that in order to ensure accountability, purchasing and taxing authority should be in the same institutional hands. Rathin (1999) argues that decentralized governments might seek to raise revenues that would add to, rather than substitute for, the central tax burden. In these circumstances, decentralized provision could potentially be more expensive than centralized provision. The structure of intergovernmental fiscal relations in a country is not only based on principles of public finance but also reflects specific contextual factors. For example, sub-national government in one country may have very low grant dependence (e.g. raise nearly all revenues from local sources), but may also do very little (be responsible for few

functions or have low levels of expenditure). This study resonates with Wolman, but the question is, does such administrative unit, thereby, possess a higher degree of decentralization than one with high dependency on grants from national government, but high level of responsibility for health services? Another issue here is cross-subsidies. Decentralization has the potential to increase inequalities; therefore, cross-subsidies are often introduced among a country's different regions. However, decentralization that incorporates cross subsidies may reduce local discretion to develop innovative programmes.

The redistribution of resources also can create political tensions between winners (administrative units receiving funds) and losers (administrative units paying these funds) and in Kenyan case the National and County governments. A further factor here concerns the European Union's concept of subsidiarity. According to this standard, the overarching goal in determining intergovernmental relations should be to push responsibility for service provision to the lowest level possible to promote participatory democracy and achieve efficiency gains from matching services to citizen preferences. From this concept has sprung much of the impetus for giving sub-national government more direct responsibility for service provision, and thereby reinforced the need for fiscal decentralization to fund those services which is not the case in decentralized functions in Kenya which entirely depends on central government funding (Jervis and Plowden, 2003).

Efficient delivery of public services in Africa and other developing regions has for a long time been hindered by highly centralized government bureaucracies. In Kenya, several efforts have been made to reduce the complexities of a centralised government to make service provision more efficient. Since independence in 1963, Kenya has worked towards

improving the health of its citizens in rural and urban areas. By 1980s, the number of the healthcare facilities had quadrupled in majority of the regions in an effort to serve the rapidly growing population. The government together with other development partners has from time to time introduced new health policies, and ratified other conventions and global commitments to ensure development in the health sector. The Kenya health policy 2012-2030 for example, provided guidelines to development in the entire health sector in line with Vision 2030 and the new constitution. Over the years, the health sector has undergone various transformations, developments, and challenges (Mills, 1994).

According to Crook (2003), devolution, despite being anticipated as a source of relief to several problems including those in the health sector, it may introduce a new set of challenges. It is important however to note the developments in healthcare service provision and point out that despite the significant economic growth, Kenya's healthcare system has performed below the expected levels. This is attributed to lack of political will and faltering commitment to its development. Both the national and county governments should increase their efforts and commit more resources to improve the healthcare sector to avert challenges as put forward by Crook.

The complaints from the County governments suggest that, the National government in Kenya, have allocated and continue to allocate less than the required amounts of revenue and other resources as compared to what is required to discharge the mandate of the County governments. There are serious human resource gaps, deficits, and administrative weaknesses coupled with chaos around pensions and the secondment of staff to the counties from the dismantled local governments that were there initially. There is evident lack of institutional capacity at the County Executive and County Assemblies. While this is

not entirely surprising, what is of concern is that the process of acquiring this capacity is not well stipulated (Agrawal and Ribot, 1999).

Kenya isn't standing alone when it comes to the influence of resource allocation on matters healthcare as a result of devolution of healthcare. In Tanzania the de-concentration type of decentralization also faced a number of challenges that culminated in its failure in the early 1980s. These challenges included, among others, increased government expenditure; increased bureaucracy in decision making from the central, regional, and district levels to the village level; and a lack of locally generated revenues as the districts were not allowed to collect tax. All these challenges led to the general problem of the slow development of the health sector in Tanzania a replica of what is happening in Kenya today (Gilson et al…,1994).

Given the deterioration in the delivery of public services, including health services, under the de-concentration system, the government reintroduced local government in 1984 through the Local Government Legislation Act of 1982 (Gilson et al…,1994). However, the reintroduction of the local government adopted a top-down modality, hence it faced some challenges such as central government bureaucracy and the extra power and authority delegated to central government ministries through their regional administrative offices to manage and control social and economic aspects of the local government. As a result, local government again failed to achieve the expected improvements in the delivery of local services, and this suppressed local democracy (REPOA, 2008).

In the early 1990s, it became evident that fundamental political, administrative and economic reforms were imperative for the government to be able to improve efficiency and

effectiveness in the delivery of public goods and services. Several socio-economic and political reforms were introduced in Tanzania during this period, including establishment of multiparty democracy, liberalization policies (which introduced the free market economy) and introduction of user charges (cost sharing) in the social services, including health (Lugalla,1997). Thus, local government and the health sector were among the reforms that were given paramount importance by the 1990s government reforms. This is because of the demand and cry from different local and international stakeholders for an effective decentralization system which would provide an enabling environment for communities at the grassroots level to participate in the decision-making process (Lugalla, 1997).

Decentralization was one of the most important components of both local government and health sector reforms aimed at transferring key functions, responsibilities, power and resources from the central government to the local authorities, as well as strengthening the capacity of local authorities. In so doing, the government adopted decentralization by devolution (D by D) strategy, in which LGAs were supposed to be largely autonomous institutions, free to make policy and operational decisions consistent with the country's laws, policies and institutions that have the power to possess both human and financial resources. It was expected that the D by D strategy would yield, among other outputs, the delivery of quality services, including health services, to the people in a participative, effective and transparent way (Gilson et al…, 1994). However, since the reintroduction of decentralization in the health sector in the mid-1990s, little has been documented on the challenges facing the implementation of this policy from the perspective of health officials and policy makers at both the national and the local authority levels. Furthermore,

reviewed studies have not shown the extent to which decentralization has increased or decreased the choices and discretion of LGAs to make their own decisions regarding council health service plans. The main aim of this study was to assess the influence of devolution on healthcare service delivery in Busia County, Kenya which the above literature plays a key role in informing this study.

This study having reviewed the existing relevant literature on the relevant study themes and having examined views of different scholars have found out that despite the writings of several scholars, there exist a gap which must be filled. For instance (Cheema and Rondinelli, 1983) believes that with decentralization of services and resources from central to local governments there will be efficiency in service delivery, but this hasn't been the case in several devolved sectors of economies. Also according to Gershberg, (1998) the majority of citizens trust local governments in service delivery compared to central government, but even with this trust there is dwindling service delivery in most devolved government especially in health sector. Mills, (1994) corroborates Gershberg school of thought and held the opinion that efficiency of public services in Africa and developing countries has for long time been hindered by highly centralized government bureaucracies but failed to give out reasons as to why even with decentralization there was limited efficiency. It is within the purview of this study that since most functions have been transferred to the counties, more resources should be given to the Counties to facilitate the performance of these functions in line with the constitutional principle that resources follow functions. Counties have reported that this has not been the case. Furthermore, it has been pointed out that getting the little resources is quite difficult. For instance, the financial assistance has been futile and if present delayed (CIC Report, June /July 2015).

2.3 Healthcare Leadership influence on Service Delivery

Koivusalo, (1999) notes that devolution of health centres occurred only when there was good governance anywhere in the world. This demonstrates the capability of governments in managing the health sector. It is also a requirement that, the health centres' staff involved be willing to transfer to local administrative units for example the counties. Local administrative organizations are responsible for primary health service delivery through health centres. The involvement of the majority of the staff in decision making will make health services devolution workable.

According to (Mills 1994), a two-tier system is best for the health sector where a lower level authority covers the largest area in which community exists and where citizens can participate, and a higher-level authority should cover the largest area to which it can deliver technical services (especially specialized hospital services) efficiently (Mills 1994). This framework implies that countries should seek to combine two major objectives, local participation and efficiency, in how they organize a decentralized healthcare system.

Successive governments in Kenya have sought to address the problems of health system by adopting a variety of ways. As long as 1994, the Government of Kenya (GOK) approved the Kenya Health Policy Framework (KHPF) as a blueprint for developing and managing health services. Central to the creation of a healthcare system is the devolved authorities' ability to use these governance tools to rationalize, integrate and coordinate previously autonomous and sometimes competing services. Such rationalization can occur vertically (between institutional and community-based services) and horizontally (among

institutional service) such as hospital mergers or among community based services (Mills, 1994).

The capture of the state by small political elite led to control of both political and economic power in the entire country. Therefore, the concept of republican government as an instrument in the service of the welfare of the people became extinct. Government ceased to serve the people and became the property of a few. Elective and appointive positions became, not the means to serve the people, but rather, avenues for amassing personal wealth. The notion of servant leadership disappeared as personal aggrandizement, corruption, mismanagement and plunder of public resources nursed by political patronage became the norm. Allocation of resources and development opportunities was done on the basis of political patronage instead of objective criteria and the most important person in this process was the President. This excluded people from government services creating a feeling of marginalization in many parts of the country. Since independence in 1963, centralisation has been at the core of Kenyan governance, with power concentrated in the capital. As a result, Kenya has been marked by spatial inequalities during this period of time. Centralization led to strong feeling of exclusions, birthing and sustaining the perception that one had to have one of their own in a key political public office to access government services and opportunities. Because of this, political and public service office became intensely valued prizes. Indeed, the presidency became the ultimate price (Goldsmith, 1995).

In effect, the levels of government must have the freedom to make decisions in the functional areas assigned to them by the CoK 2010 without undue interference from the other. Despite the Constitution creating the two levels of government and 47 counties,

Kenya is still a unitary state. The Kenyan constitution 2010 emphasises on a greater devolution of budgets and decision-making with the aim of a more flexible response to the needs of individuals who are more concerned with the provision of service than with the provider of service. The fourth schedule (article185 (2), 186 (1) and 187 (2)) establishes the distribution of functions between the National government and the County governments where the government handles National referral health facilities and Health policy, while County government handles County health services, including, county health facilities and pharmacies; ambulance services; promotion of primary health care and licensing and control of undertakings that sell food to the public (CoK, 2010). However, County governments applied for the transfer of functions (CGA 2012).

In as special issue 1795 of the Kenya Gazette Supplement No. 116, Legislative Supplement No. 51, legal notice no. 137, health services were transferred to the counties. County health services including, County health facilities and pharmacies and county health facilities including county and sub county hospitals, rural health centres, dispensaries, rural health training and demonstration Centre's. Rehabilitation and maintenance of county health facilities including maintenance of vehicles, medical equipment and machinery can only succeed under very good management. It has been noted that the power-play and dynamics that relate to devolution have been paralyzing and intriguing at the same time. The Transition to Devolved Government Act 2012 established the Transition authority to facilitate the smooth transition from centralized government to devolved governments. The various process including the transfer of assets, secondment of staff, establishment of the payroll, capacity building of the county government and the

setting up of civic education units among others have been chaotically operated leaving devolution suffering (Bossert, 1998).

Whilst the principles of public service delivery in the county are very clear and the standards and norms for public service delivery have been outlined, the current situation is informed by the tensions around the transfer of functions and decision making on what services should be offered by the county government in the wake of the reality that the county governments do not have the requisite resources and technical capacities (CGA, 2012).

It is however important to note that decentralization is not a guarantee of better health sector management. In parts of the world, countries appear to be retreating from key tenets of decentralization and are instead, re-centralizing important health system functions. For example in the Nordic countries, in 2002 Norway recentralized operating authority from 19 elected county councils into state hands, then allocated it to 6 new, appointed regional boards. Moreover, health sector financing in Norway has remained a national not a regional responsibility. Similarly, the Danish national government in 2006 recentralized both operating and financing responsibility away from its 14 elected county councils, dismantling these bodies to give operating authority to 5 new regional entities, while making the financing of healthcare an exclusive function of the state. Further, Sweden and Finland also are contemplating restructuring their healthcare systems, along similar if somewhat less dramatic lines. The new Nordic policy picture is thus one in which countries that had placed decentralization at the core of their health sector strategies now are reworking key elements of that prior strategy (Koivusalo, 1999)

One can also observe important elements of recentralization in several central European countries. In both Poland and Slovakia, the previously regionalized sickness fund structure has now been pulled back into a single national organization, enabling it to be more directly supervised by national ministries of health and finance. In Tanzania decentralized recruitment of health workers resulted in a more realistic distribution of staff compared to centralized recruitment, where the posting of staff was less responsive to the specific needs of the districts (Lugalla, 1997).

In Ethiopia, decentralization strategies were implemented with different degrees of success. Decentralization to the regional level was associated with improved health outcomes and HSD outputs, though these results were flattered by having a very low baseline level. Decentralization to the district (Woreda) level was probably premature, particularly given the weak management capacity at that level and the lack of consolidation of gains at the regional level (Bossert, 1998). Bossert arguments of weak leadership in decentralized units didn't point out how to improve service delivery at the decentralized units of government and its one of the aims of this study to improve on Bosert's 1998 study and fill the existing gap.

2.4 Influence of Organizational Structure on Quality Service Delivery

There are countries that have had successful healthcare devolution and an example is Thailand. Healthcare service provision was devolved to Local Administrative Organizations leading to more management flexibility and quicker decision making. This logically follows the shorter chain of accountability since staff experience management of Local Administrative Organizations to be 'closer' to the people compared to the (provincial) Department of Health. The downside of the Thai system is that there is limited

change to existing governance structures, which created an additional line of accountability for those health centres that devolved their system. The governance structures should therefore balance the trade-off between transparency versus the administrative burden it puts on health facilities or regional government departments. One can point out at the failure to put in place escalations mechanisms for Local Administrative Organizations, which raises the question of what will happen and who will act upon unwanted events at health facilities residing under these Local Administrative Organizations. Across the globe, experiences in devolving the health function are mixed. Some countries or regions have succeeded in leveraging devolution to improve healthcare while others have failed. In the Philippines, devolution relatively increased resource allocation, facilitated greater citizen participation in addressing unique health needs and bolstered decision making power at the local levels (Mackintosh, 1999).

In Ethiopia the concept of devolution was introduced in 1996 and was seen as the primary strategy to improve health service delivery in the country. It formed part of a broader devolution strategy across different sectors of which healthcare was one. Devolution first took place at regional level and was further extended to the district or woreda level in 2002 (Sameh et al…, 2009). Ethiopia adopted a three-tiered system of Healthcare facilities which consisted of national referral hospitals, regional referral hospitals, district hospitals together with primary healthcare facilities.

Level one: The woreda (district) includes a primary hospital (with population coverage of 100,000 people), health canters (1/25,000 population), and their satellite health posts (1/5,000 population) connected to each other by a referral system. Health centres and health posts form a primary healthcare unit with each health centre having five satellite

health posts. Level two: is a general hospital with population coverage of 1 million people and Level three is a specialized hospital that covers a population of 5 million. Offices at different levels of the health sector, from the Federal Ministry of Health (FMoH) to rHBs and woreda health offices, share decision-making processes, powers, and duties where FMoH and the rHBs focus more on policy matters and technical support while woreda health offices focus on managing and coordinating the operation of a district health system that includes a primary hospital, health centres, and health posts under the woreda's jurisdiction (Sameh et al.., 2009).

Through the devolution mechanism, districts received block grants from regional government and they, in turn, were entitled to set their own priorities and determine further budget allocation to healthcare facilities based on local needs. Consequently the district levels were responsible for human resource management, health facility construction and supply chain processes. Impressive improvement of service delivery was observed despite some challenges in the initial stages. Ethiopia has moved from centrally-organized authority to a situation where block grants are redistributed from regional governments to districts. The districts, in turn, can set their own priorities and are free to further allocate this budget to health facilities. On the one hand, districts are relatively free to spend their budget on whatever health facility they want while on the other hand, it does mean that districts still rely on budgets that are allocated to them. It was found in Ethiopia that communication channels with communities were not well established whereas in Ghana, communication channels were established where mechanisms for local community participation have been established at different levels (Sameh et al…, 2009).

Ethiopia chose to gradually implement its devolution mechanism through first devolving responsibilities to regional level before further devolving it to district level. This approach created a platform for managerial capacities to evolve within these regions and districts. International studies found that a national implementation strategy is often lacking and that process objectives are not always shared and communicated with stakeholders. In some instances, the plans for devolution are there, but the actual implementation plan with interim milestones is absent. Having such a plan in place will help to identify what activities and policies are required at what point in time to achieve the objectives of devolution. It will furthermore help in explaining and operationalization of a national strategy. When it comes to finance in Ethiopia, budgets set the tone, districts are financed through block grants that regions receive. These block grants are based on the size of the population and not necessarily on the need of the population (Mackintosh, 1999). According to this study therefore, Mackintosh, (1999) argument on Ethiopia's case is relevant to the Kenyan system in how organizational structure is influenced by resource allocation to county governments, which in turn will influence public service delivery as it points out the existence of a gap on public health sector institutions structure in their role of providing public health care.

Devolution was introduced in Uganda in 1997 under local government Act. The main focus was on education, health, and agricultural advisory services, as well as the management of natural resources in Uganda (Bernard et al.., 2011). Studies show that there has been no improvement in health services with many health status indicators either stagnating or worsening. In general, decentralization of education and health services has not resulted in greater participation of the ordinary people and accountability of service

providers to the community. Lack of community participation, inadequate financial and human resources, a narrow local tax base, a weak civil society, underscored the need to ameliorate them if devolution was to attain the anticipated results.

The Ugandan case cautions against the tendency to romanticize devolution as the new-found solution for past and current institutional and socio-economic distortions and argues that devolution itself can make state institutions more responsive to the needs of the communities, but only if it allows local people to hold public servants accountable and ensures their participation in the development process (Per et al.., 2008). Uganda undertook a radical decentralization following the introduction of a new Constitution in the mid-1990s. The reforms were home-grown and there was an unusual degree of commitment to them by the government of the time. By the late 1990s Ugandan local governments were among the most empowered and best financed in Africa. Local governments were given block grants and had substantial autonomy over budgeting and staff. However, over time it became apparent that many local governments were performing poorly in delivering services. A public expenditure tracking study revealed that very little funding was reaching schools. Central agencies that had initially supported decentralization began to realize the impact on their power and resources and argued for stronger central controls in the form of conditionality's on grants.

In Tanzania the ministry of health and social welfare (MoHSW) is responsible for setting national standards, conducting performance audits and building capacity of facilities for local government authorities and the prime minister's office – regional administration and local government (PMO-RALG) monitors and coordinates all sectorial activities in line with the policies and guidelines of the respective ministries. The ministry of health and

social welfare also collaborates with the prime minister's office – regional administration and local government and the president's office public service management to recruit and distribute human resources for health throughout the country. At the region, there is the regional health management team (RHMT) and the social service section under the regional secretariat, which perform several activities, including coordinating and advising on the implementation of health policy in the region, monitoring proper management of the health services in the region and building the capacity of LGAs in health service delivery (Crook, 2003).

At the district level, there are various local authority organs, including a full council whose responsibility is to deliberate on and approve district health plans and budgets, and the council health service board (CHSB) which perform various functions including discussing and amending district health plans and budgets and identifying and soliciting financial resources for running council health services. The CHSB prepares comprehensive council health plans, ensuring the provision of transport, drugs and medical supplies to health facilities, carrying out supportive supervision to lower level facilities and ensuring the provision of quality health services in the district. The health facility governing boards and committees are important decentralised structures at the grassroots level which perform various functions including discussing and approving the facility's plans and budgets, identifying and soliciting financial resources for running the facility, and advising and recommending on human resources concerning recruitment, training, selection and deployment to relevant authorities (Crook, 2003).

For example, after Tanzania undertook decentralization for all HRH management functions to the district level, rural districts were unable to attract and retain highly skilled staff such

as medical specialists, leading the country to re-centralize some of the HRH management functions. Some studies suggested that certain HRH management functions, including recruitment and distribution of highly specialized health workers, in-service training, and management of staff salaries, are best managed centrally; while other functions like staff appraisals, promotions, recruitment and deployment of lower cadre health workers are best handled in decentralized units. Another commonly reported HRH management problem linked with decentralization has been frequent delays and disruptions in payments of staff salaries; and challenges in managing in-service training and other career progression initiatives. In addition, several studies identified challenges in the management of the responsibility transfer process from central level to decentralized units, in the early stages of decentralization. This has often been associated with confusion, fear and anxiety on the part of health workers. In many instances, these HRH management challenges have resulted in low staff morale, industrial action like strikes and mass resignations (Lugalla, 1997).

In Kenya's devolved system, healthcare is organized in a four tiered system: Community health services: This level is comprised of all community-based demand creation activities, that is, the identification of cases that need to be managed at higher levels of care, as defined by the health sector. Primary care services: This level is comprised of all dispensaries, health centres and maternity homes for both public and private providers. County referral services: These are hospitals operating in, and managed by a given county and are comprised of the former level four and district hospitals in the county and include public and private facilities. National referral services: This level is comprised of facilities that provide highly specialized services and includes all tertiary referral facilities. The

counties are responsible for three levels of care: community health services, primary care services and county referral services. The national government has responsibility for national referral services (CGA, 2012).

In the devolved government, the Kenya Health Policy 2012 – 2030 provides guidance to the health sector in terms of identifying and outlining the requisite activities in achieving the government's health goals. The policy is aligned to Kenya's Vision 2030 (Kenya's national development agenda), the Constitution of Kenya and global health commitments (for example the Millennium Development Goals), and uses a three-pronged framework (comprehensive, balanced and coherent) to define policy direction (Gok, 2007).

The Kenya Health Policy 2012-2030 offers guidelines to ensure momentous improvement in the status of health in Kenya, in line with the provision of the new constitution of Kenya 2010, Vision 2030, and other global commitments. The policy exhibits Kenya's health sector's obligation, under the national government supervision, to ensure that Kenya attain the highest possible standards of health, in response to the needs of its citizens. Health Policy 2012-2030 is designed to be all-inclusive, balanced, and rational. Therefore, it concentrates on the two major obligations of health, including contribution to economic development provided in the new constitution of Kenya 2010 and Vision 2030 (Ministry of Health, 2012). To respond to these constitutional demands and prepare for the smooth transition of health services to the devolved governments, the Ministry of Public Health and Sanitation and the Ministry of Medical Services held consultative meetings with partners and other stakeholders to discuss how devolution will be implemented (Gok, 2012).

When implementing devolution, proper consultation is considered as one of the criteria before, transferring national budgets to sub-national levels. In Uganda, the demands were supported by donors who were financing a substantial proportion of the delivery of basic services. The multiplication of conditional grants coupled with increased fragmentation of local governments removed much of the fiscal autonomy of local governments, and rendered them increasingly impotent in terms of making genuine decisions about local priorities. There has been little impetus to reverse these trends, with the result that Ugandan local governments are now relatively weak. Despite much initial enthusiasm, the pace and trajectory of Uganda's reform proved too ambitious, and in addition there was too much emphasis on formal development of the system and too little on developing local accountability. This experience illustrates why 'hastening slowly' might be the fastest way for devolved governments to achieve real a lasting autonomy (Fottler, 2011).

The logic of decentralization is based on an intrinsically powerful idea. It is, simply stated, that smaller organizations, properly structured and steered, are inherently more agile and accountable than are larger organizations. For example, a number of the more radical innovations concerning the organization and management of health services, and consequently raising issues of governance and accountability, are being introduced in England. A particular example is the increased use of the private sector in service delivery. There appears as yet to be little desire to replicate such approaches in the devolved administrations. In both Scotland and Wales, the emphasis on traditional central control combined with local accountability to citizens persists. Within the English healthcare services, the degree of devolution to regions or cities remains very limited. Neither London nor the English regions have, as yet, the autonomy or the powers to develop distinctive

approaches at their level. Despite the overemphasized and rhetoric in Scotland and Wales about the importance of better health as opposed to better health services, there is relatively little perceptible impact so far on the substance of policy (Fottlter, 2011). From Fottlter's agreements this study points out a gap in that despite decentralizing health services not always does the organizational structure influence service delivery positively.

National governments still have strong say into what budgets are allocated to what region or district, including what parameters underpin the size of the budget. This puts constraints on the levels of authority sub-national entities have to influence the budget, specifically if this is based on population numbers rather than need and demographic factors. The risk of using budgets per region is the insufficient ring-fencing of the budget for healthcare. Combined with a lack of managerial capacity, this can lead to underfunding of health service delivery (Fottter, 2011).

A short preview on devolution in Philippines, shows that, in the first year of implementation, there was decreased hospital occupancy and health centre utilization, decreased procurement of drugs and medical supplies, decreased maintenance and operating expenses for health facilities, loss of managerial and fiscal control of hospital administration, resignation of key personnel and low staff morale. The Problem was worsened by perceived political recruitment and retention of health staff among others (Fried, et al.., 2008). A study of five years of devolution in Philippines also revealed problems of understaffing, unmaintained infrastructure, unrepaired and un-replaced equipment. A lot of resources were used on staffing and less on other resources necessary to deliver the services to the people, the situation in Kenya may even be more serious if devolution process is poorly managed. From the review of the above literature, it is evident

that devolved units still depend on central government for funding something which affects their performance and responsibility for example the case of United Kingdom, Thailand, Ghana and Ethiopia.

It is also evident from the literature reviewed that for countries that devolve healthcare, there should be legislation stating how the different health departments will work and communicate.

2.4.1 The effects of Devolution on Healthcare

Devolution is a form of decentralization and it is simply defined as the process of transferring decision-making and implementation powers, functions, responsibilities and resources to legally constituted, and popularly elected local governments. Devolution in Kenya is based on the supremacy of the Constitution, sovereignty of the people and the principle of public participation. Supremacy of the Constitution means that the Constitution is the supreme law of the Republic. Therefore, devolution being an aspect of the Constitution binds all persons and all State organs at both levels of government. The sovereign power of the people on the other hand, means that the power to rule and make laws in Kenya lies with the people of Kenya and can be exercised only in accordance with the Constitution at the national and county level either directly or indirectly, through their democratically elected representatives (Faguet et al..,2001)

Devolution is one of the concepts in the Constitution that has brought about a complete overhaul in Kenya’s system of governance. This is because it is a new aspect in the Kenyan governance system. The need for Devolution has been seen in many countries and it is informed by the need to have power sharing, checks and balances in governance and the decentralization of resources.

In Pakistan, District Administrators failed to prioritize health hence limiting resource allocations. Healthcare delivery thus stagnated despite devolution (Misra et al…, 1994). The World Bank warns that poorly and hastily implemented devolution can adversely affect health service delivery. Devolution must thus get the resource, policy and institutional imperatives of health service delivery right in order to succeed. In Thailand, there is an increased level of responsiveness to the community the health centre operates in and the patients it caters for. This, in turn, also impacts positively on community participation and as a result, health centres find the number of patients visiting health centre's increasing. The lesson learnt from Thailand is that devolving responsibilities to health facility level might be less effective compared to devolving to a region or district. This will also prevent different health centres and Local Administrative Organizations developing in different directions. Thailand has devolved Local Administrative Organizations contract with the local players which contributes towards achieving universal coverage in the country, as regional budgets are set based on population. Thailand has also set itself a target of transferring at least 25 percent of the national budget to Local Administrative Organizations.

Ghana is an example where important building blocks are in place. They have established district health offices (as part of the Ghana Health Service) and District Assemblies. These have responsibilities ranging from planning and budgeting to operational management of health facilities to prevention and health promotion. There is, however, no legal or policy framework that enforces a coordinated approach for these entities on a district level. Up until now, policies have been confusing, contradictory and inconsistent. Because of this,

governance and accountability of health facilities has weakened due to overlap and duplication of reporting lines.

The reviewed literature above have a gap in that it portray stakeholders themselves as having a limited understanding of government's plans and process objectives in terms of decentralization and devolution of responsibilities to sub national levels. In Ghana for example, although the building blocks are in place, the governance and accountability structures lack the means of allowing different levels of authority 'talk' to each other due to the fact that they are not fully developed. As is seen in Ghana, different role players impact on the (performance of) the local health systems. Since there is no overarching strategy, policies, or regulations, many stakeholders have a limited understanding of government's plans and process or objectives in terms of decentralization or devolution of responsibilities to sub-national levels. Ghana budgets for regions and districts that, in turn, can allocate budget to health facilities (Jones, 1996).In Uganda, decentralized HRH recruitment has also been associated with inability to attract highly skilled health workers in rural remote areas in rural districts. Therefore this study will fill the existing literature gaps with its findings and recommendations.

2.5 Organization of Healthcare in the Devolved System

In a devolution process, it's important to pay close attention to leadership and governance, health service delivery, health infrastructure and equipment, human resources for health, health information systems, review procedures of health-related laws, and healthcare financing. Most doctors are taught to manage diseases, not institutions or organizations, so they do not have management and leadership capacity.

The government both the national and counties developed a "roadmap" to guide the fulfilment of its mandate and the success of the devolution process. The Transition Authority was put in place to oversee the: Mapping of all government transition activities, capacity assessment and development, functional analysis, competency assignment and costing, resource mobilisation, strategic communication and engagement, performance management framework and inauguration and operationalization of county governments. The sole purpose of this formation of a Transition Authority was to fast track smooth movement from the central government to counties. The Task Force on Devolved Government included a proposed mechanism for the transfer of functions to counties in the draft Transition to Devolved Government Bill. The mechanism has four elements: criteria for assessing whether a county is ready to receive a function, applications by individual counties for specific functions to be transferred to them (CGA, 2012).

According to (GoP, 1998) this approach has several advantages. It establishes a natural filtering mechanism to be able to apply; counties must have some capacity first. It provides a transparent process that is relatively free from discretion (as far as this is possible), and it puts an independent and neutral body in charge. However, there are also some disadvantages**.** It is likely to generate a large volume of applications, with perhaps between 500 and 2,500 individual applications being generated. The Transition Authority will have to rely on line ministries to help it evaluate applications, because it is unlikely to have the technical expertise to assess whether a county is ready to carry out a function.

In Kenya's devolved system, healthcare is organized in a four tiered system: Community health services: This level is comprised of all community-based demand creation activities, that is, the identification of cases that need to be managed at higher levels of care, as

defined by the health sector. Primary care services: This level is comprised of all dispensaries, health centres and maternity homes for both public and private providers. County referral services: These are hospitals operating in, and managed by a given county and are comprised of the former level four and district hospitals in the county and include public and private facilities. National referral services: This level is comprised of facilities that provide highly specialized services and includes all tertiary referral facilities. The counties are responsible for three levels of care: community health services, primary care services and county referral services. The national government has responsibility for national referral services (Commission for the Implementation of constitution, 2014).

2.6 Healthcare Workers Competence Influence on Healthcare Quality Service Delivery

According to Fleishman and Bartlett (1969) competence encompasses knowledge, skills, abilities, and traits. It is gained in the healthcare professions through pre-service education, in-service training, and work experience. Competence is a major determinant of provider performance as represented by conformance with various clinical, non-clinical, and interpersonal standards. Measuring competence is essential for determining the ability and readiness of health workers to provide quality services. Although competence is a precursor to doing the job right, measuring performance periodically is also crucial to determine whether providers are using their competence on the job. A provider can have the knowledge and skill, but use it poorly because of individual factors (abilities, traits, goals, values, inertia, etc.) or external factors (unavailability of drugs, equipment, organizational support, etc.)

According to Boyatzis (1982) competence refers to a person's underlying characteristics that are causally related to job performance. Competence is defined in the context of particular knowledge, traits, skills, and abilities. Knowledge involves understanding facts and procedures. Traits are personality characteristics (e.g., self-control, self-confidence) that predispose a person to behave or respond in a certain way. Skill is the capacity to perform specific actions: a person's skill is a function of both knowledge and the particular strategies used to apply knowledge. Abilities are the attributes that a person has inherited or acquired through previous experience and brings to a new task (Landy, 1985), they are more fundamental and stable than knowledge and skills (Fleishman and Bartlett, 1969).

Health workers acquire competence over time (Benner, 1984). Typically, pre-service education or an initial training opportunity creates a novice who, after additional training and hands-on experience, reaches a level that can be certified as competent. Although competence is considered to be a major milestone in professional development, it is not the final point. That comes with proficiency, and the ultimate status of expert comes after many years of experience and professional growth (Benner, 1984).

2.6.1 Relationship between Measuring Healthcare workforce Competency and Quality Service Delivery

There are many good reasons for measuring competence. Ministries of health, professional organizations, and healthcare organizations must ensure that appropriate expectations for competence are set and that their staff performs to standard. Healthcare organizations must meet certain criteria to provide services. These organizations through certification, licensure, and/or accreditation are able to exert control on health providers and, as a result, to influence the quality of care. Although most health providers must demonstrate

minimum competence during training to move up to the next level or graduate from a course, not all healthcare organizations assess job or skill-specific competencies before offering employment. Reasons why healthcare organizations should measure competence include:

According to (Lenburg, 1999), in healthcare reform the increasing complexities of healthcare delivery and changing market conditions have forced health policy-makers to promote the assessment of initial competence of students and new graduates and the continuing competence of experienced and certified practitioners in order to improve healthcare service delivery. In the United States, this has led to various reforms affecting teaching and the methods used to assess students' actual competence. The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) has required specific validation of the competence of healthcare providers for institutional accreditation (JCAHO, 1996). With rapid technological and scientific innovations, U.S. employers are spending substantial resources to assure competencies of new and existing health staff. These health institutions are using specific standardized tests to document the readiness of employees for full practice responsibilities (Lenburg, 1999).

According to Smith and Merchant (1990), organizational performance is critical if service providers to effectively treat their clients. And if not, the problem may be lack of competence. Healthcare organizations need to assess individual and organizational performance periodically to assess the efficacy of their services. The results help healthcare organizations determine whether they need to design training and/or continuing education interventions for improving provider performance. Comparing assessments of competence and job performance may indicate the extent to which the organization provides the support

needed for quality care. High competency and low performance may signal that an organization is not providing the needed resources, has not clarified standards of care, or is not rewarding effective performance or correcting poor performance and thus the need of rationalization competency and provision of necessary resources.

In reference to liability and ethics healthcare organizations are responsible for the quality of care their staff provide and consequently must ensure that their staffs are competent and can meet standards for the provision of care. Assessing providers' competence periodically enables healthcare organizations to meet this crucial responsibility. Also competency assessments can be used to monitor organization-wide knowledge of policies and procedures related to high-risk areas. Feedback from these assessments can be used for training and continuing education of providers and to improve overall organizational performance. Certification and recertification of providers: Competency assessment is an integral part of the certification and recertification processes of service providers. For example, recertification programs in the U.S. use examinations and performance assessments as "snapshots" of competence every seven to ten years (Bashook and Parboosingh, 1998). This aspect if incorporated into healthcare systems in Kenya will boost the competence and service delivery of healthcare institution and workers therein.

Smith and Merchant (1990) holds the opinion that competency assessment can determine the efficacy of training interventions in closing knowledge and skill gaps and to assess and improve training. Low scores on competence assessments after training may indicate that the training was ineffective, poorly designed, poorly presented, or inappropriate. Trainers can use this information to improve training content or delivery. If the assessments aim to improve specific components of training, the trainer may be able to determine where more

information is needed, which exercises require clarification, or if more time is required to cover a topic (Smith and Merchant 1990).

Health workers need a large number of competencies for providing quality services. Benner (1984) and Fenton (1985) have proposed several domains with specific competencies that are critical for nursing care. Although these domains have been defined from a nursing practice perspective, they apply equally to other types of health workers. Some of these competencies affect the quality of care directly and others indirectly. While health workers can gain knowledge about various competencies during pre-service education, skills related to these competencies are further advanced during practicum or on the job. In addition, mentors and preceptors can further assist to improve health worker competency.

Having reviewed the relevant literature , this study finds the works of scholars like Fleishman and Bartlett (1969) who held that competence encompasses knowledge, skills, abilities, and traits gained in the healthcare professions through pre-service education, in-service training, and work experience, and are necessary efficient service delivery, the study notes that despite of its existence with even its aiding tools of measurement, there exits cases of negligence in service delivery, therefore this study will fill the above said gaps with its findings and by way of making recommendations.

2.8The Principal Agent Theory

This study applied and was guided by the principal agent theory developed by Bossert (1998). The theory postulated by Bossert is also known as Decision Space Approach. From the perspective of the theory, principal agent is the national government and decentralization is seen in the context, as being the objectives of the principal (national

government) and how the principal uses various mechanisms of control to assure that decentralized agents (county governments) work toward achieving those objectives. The theory by Bossert suggests that, decentralization requires additional concepts to capture the widening range of discretion or choice allowed to agents in the process of decentralization which differentiates decentralized principal agent relationships from centralized relationship, this concept is called ―decision space (Bossert, 1998). Although the theory seems to suggest a superior subordinate relationship between the national and county government, the relationship is in fact interdependent. The theory looks at various functions and activities over which local authorities will have increased choice. It looks at decisions in selected functional areas. According to the theory, decisions in these areas are likely to affect the systems performance in achieving the objectives of equity, efficiency, quality and financial soundness. In this case, decisions made regarding functional areas could affect delivery of healthcare either positively or negatively.

The first element in the case of healthcare in Busia County is the human resources function. According to Bossert (2008), he advocates for increased flexibility in decision making processes concerning human resources. He particularly emphasizes that managers should be given room to hire and fire so as to increase efficiency and quality of service. However, there is need for a cautious approach as this power can be abused if not managed well. Currently, county governments guided by the national standards prescribed by an Act of Parliament (Constitution of Kenya, Article235) are responsible for hiring and firing of staff. Each county has a public service that recruits its public servants (health workers) and undertakes disciplinary measures.

Secondly, is the element of information and monitoring function. Bossert (2008), points out at the crucial role of information and monitoring to the principals as they evaluate how and whether the agents are achieving the principals' objectives. He also acknowledges that the agent's control of information is crucial to the negotiating power of the agent visa-vies the principal, pointing out that central ministries need routine information systems through which their agents must report. For example, the National Health Management Information System that is coordinated at national and county levels is a good initiative. Supported by USAID, the first phase that entailed building county health information network (CHIN), to meet needs of the health sector has been completed. It began with four health facilities per county and intends to expand to six in the subsequent phases. The network will greatly help in providing a reliable link between health facilities and county department of health through internet connectivity and thus ensures communication, data sharing and information sharing within the entire county health system (Barnley, 1997). It is important for county governments to have crucial health data that will help in achieving health devolution objectives on delivery care.

The third element is the finance function. Bossert underscores the importance of decision space in making financial decisions, he argues that key decisions on sources of revenue and allocation of expenditure are likely to have significant influence on equity and financial soundness, although he acknowledges that some allocation decisions about the organizational structure of services are also likely to have an important impact on efficiency, quality and equity. For instance, as argued by Barkan and Chege, (1989) increased hospital autonomy may empower hospital management to make decisions to improve efficiency and quality of services. According to the Ministry of Health (2014), the

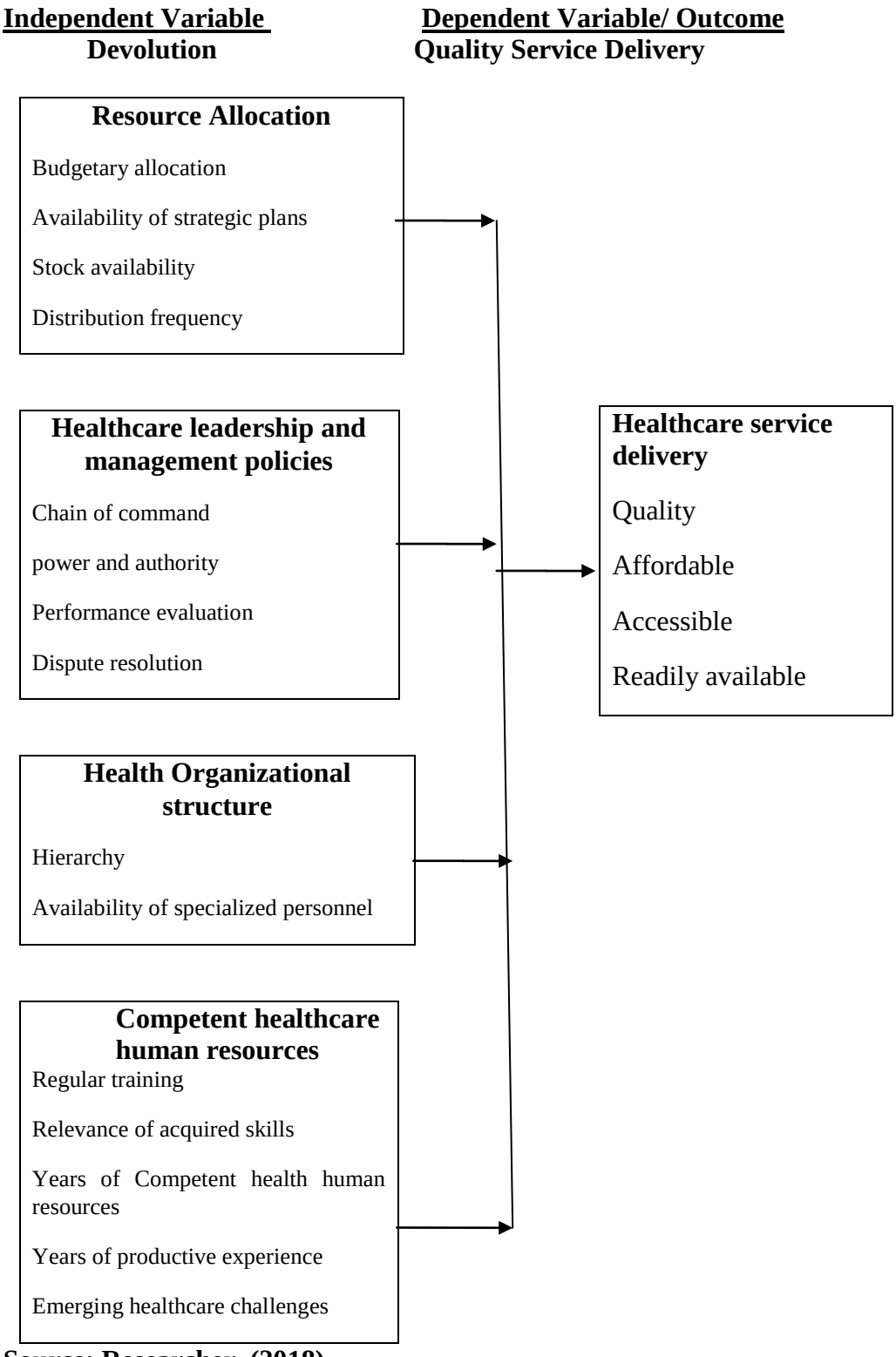
current situation in Kenya is such that counties are required to finance health service provision for primary and secondary care from their block grant allocation. Access to publicly provided services such as free maternity care depends on budget allocations at county level (MoH, 2014). This means that counties that value maternity services, particularly child birth services increased allocations for the same.

The fourth element is the governance function. The decision space approach stresses the importance of governance rules in influencing the role local political actors, beneficiaries and providers can play in making local decisions. These rules structure local participation in a decentralized system. The WHO (2002) supports leadership and governance as one of the health building blocks. Proper leadership and governance in counties will ensure maternal mortality is reduced. Counties with proper leadership will go a long way to improving maternal health by improving childbirth services. One such example of good leadership is Makueni County. In a recent Infotrak Limited poll, a local pollster and Research Company, the county was ranked highest in provision of health services, having invested in emergency services such as ambulances and rapid response motor bikes, this has enabled many women to reach hospital in good time, thus saving lives.

The theory as espoused by Bossert is not devoid of weakness. One such weakness is that the theory does not touch on the issue of governance in terms of political setup. The political setup in different countries differs and Kenya‘s political structure is unique and its impact on devolved healthcare needs to be investigated. Second, it does not talk about service delivery function that hinges on facilities and medical supplies, an important variable in this study. Despite this weakness, the theory was seen as progressive in the

sense that it is concerned with issues that matter such as equity, efficiency, quality and financial soundness. It was useful because it greatly helped to uncover other issues highlighted in the study, and therefore, was chosen as the main theory in this study. It exposed some of the important variables critical in assessing the effects of devolution on healthcare services and therefore, the study focused on these variables in depth to assess the quality of healthcare services under the devolved system.

2.8.1Conceptual Framework



Source: Researcher, (2018)

The independent variable is guided by certain determining factors (indicators) that will have influence on the dependent variable only measurable through analyzing the outcome of their interaction. The indicators include leadership, financial capability, infrastructure, workforce and health products and technologies.

From the above figure, it can be deduced that the availability of resources influence the delivery of quality healthcare services and without the resources healthcare services will be poor. Also a well-organized health structure leads to efficient communication and reporting and thus quality healthcare service provision. With Competent healthcare human resource there will be effective healthcare services and this confirms the influence of competency of healthcare workforce in healthcare service delivery.

The dependent variable is influenced by the determining factors that have a greater role in ensuring success of devolution. Successful determinants lead to delivery of efficient, cost-effective and equitable health services, sstakeholder participation and accountability in health service delivery, effective monitoring, and evaluation, reviewing and reporting systems which are likely to lead to a better health care.

2.9 Summary of the Chapter

This chapter reviewed literature in line with research objectives by examining different scholarly work. It also discussed the theoretical and conceptual frameworks as used in the study. The next chapter will be discussing the research methods used in the study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This section describes the research design, target population, sample size for the study, sampling techniques used, data collection and data analysis. At the end the researcher concludes by looking at the ethical issues that may arise in the course of this study.

3.1 Study area

Busia County covers an area of 1,696 Kilometres Square with 7 sub counties and 35 wards. The sub counties which are also constituencies include: Funyula, Budalangi, Butula, Matayos, Nambale, Teso South and Teso North (IEBC Electoral Boundaries, 2013). The 2019 population of Busia was estimated to be 893,681 people with females numbering 467,401 (52.3%), males 426,252 (47.7%) and the intersex 28(0.003%) respectively (Kenya National Bureau of Statistics, 2019). Busia County has four level 4 hospitals, 1 private hospital, 12 health centres and 3 nursing homes. The doctor population ratio stands at 1:41,200. The county has poor access to healthcare services whereby 10.3% of the population are within less than 1km from the nearest health facility, while 19% are within a radius of 1.2 – 4.9 km making 70.7% of the population (Busia CIDP 2013).

Figure 1: Map Showing Busia County

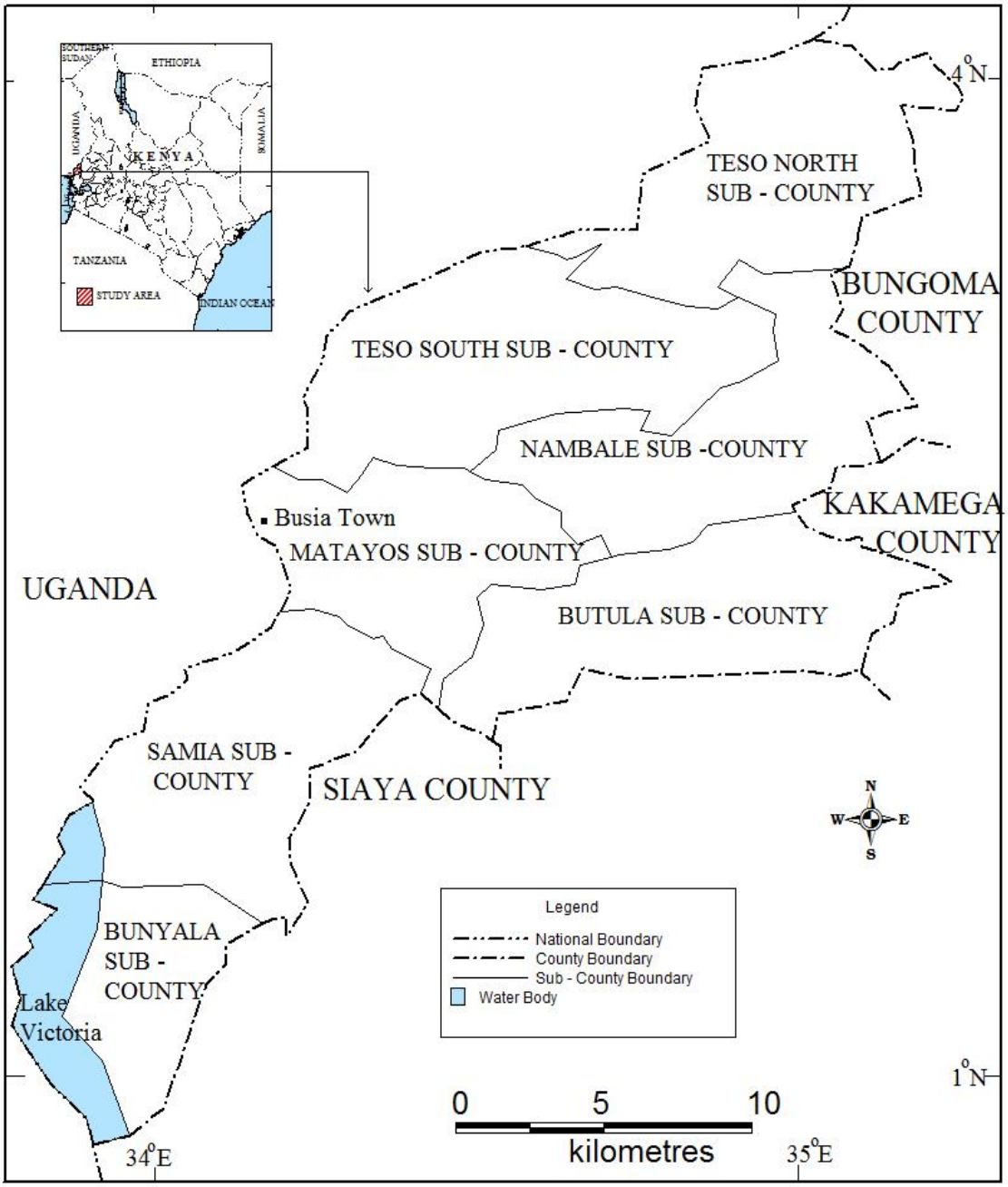


Figure 1: Map of Busia County Administrative Unit.

Source: *Moi University Geography Department GIS Lab*

3.2 Research Design

A research design is the arrangement of conditions for collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy in procedure. It is a conceptual structure within which research is conducted. It constitutes the blue print of data collection, measurement and analysis (Mugenda and Mugenda, 1999). A descriptive research design was employed to assess the effects of devolution on the healthcare sector in Busia County. The design is suitable for data collection and its ability to understand the nature of the situation as it is at the time of the study.

3.3 Target Population

The target population in this study comprised of all health workers in Busia County, county assembly health committee, county officials in the department of health and the residents of Busia County. This population was almost said to be infinite, since the population of members of public could not be easily determined. The researcher was however able to estimate the target population using the Kenya National Bureau of Statistics (KNBS, 2013) data that estimates provided to be 816,452this simply shows that they are more than 100,000.The number of county officials was determined by visiting the Busia county government offices with a request to carry out this research study.

3.4 Sampling Techniques and Sample Size

The study used purposive sampling and simple random sampling techniques to data collect data and Yamane Taro's (1967) formula to calculate the sample size.

3.4.1 Sampling Techniques

The study used purposive sampling and simple random sampling techniques in data collection. This assisted in selecting the right respondents for this research study. This was

informed by the fact that the researcher targeted specific county officials with authority and ability to provide information on healthcare services in the county, in relation to study objectives. The purposive sampling was therefore instrumental in selecting the key informants of the study who were deemed to have relevant information for the study. Simple random sampling method was used to sample the residents of Busia County who were the main consumers of healthcare service in the study area.

3.4.2 Sample Size

The sample size for this study was determined through a combined analysis of the target population based on knowledge from Yamane Taro's (1967) formula provides that at 7% precision level for population above 100,000 a sample size of 200 respondents is appropriate. Yamane Taro uses the following formula to arrive at his sample size.

n=N/(1+N(e)2

Where n=sample size

N=target population size

e =level of precision (sampling error)

Where; n=N

1+N (e) 2

N=0ver 100,000

1+ 100,000(10%) 2

= 200 respondents

Therefore, the researcher considering that this is a social research and should yield above 50% response rate in order give valid and reliable data, the researcher chose to use 200 respondents. This was expected to be enough to give information that can be used to give inference to the whole population of Busia County.

Table 3.1 Target population and sample size

Target population	Sampled size
County officials	50
county Assembly health committee members	10
Residents of Busia County	70
County health workers	70
TOTAL	**200**

Researcher, (2018)

The respondents were purposively sampled where chief informants were interviewed and information from other respondents was obtained through questionnaires. The sampled size included the CEC Health, Chief Officer Health, Health Directors, Sub county administrators, hospital administrators and Ward administrators. Residents of Busia County were also sampled by use of simple random technique.

3.5 Data collection instruments

The study employed qualitative and quantitative approaches. It was therefore within the jurisdiction of the study to utilize both the secondary and primary data. Primary and secondary data collection utilized the following instruments.

3.5.1Primary data collection instruments

Questionnaires and interview schedules were used in data collection.

3.5.1.1Questionnaires

Questionnaires are appropriate in collection of data for studies covering a large area like this one, furthermore questionnaires are cheaper to administer since they can be mailed or handed over to respondents directly. Another merit is the advantage it gives considering

that it eliminates biasness since the researcher does not have control over respondent's choice of answers. The disadvantage is that it discriminates on the basis of literacy and also one can get very low response rate interfering with the validity and reliability of the data. The researcher developed structured questionnaires which were administered to the respondents which included the residents of Busia County and health care workers. The respondents filled the questionnaires and upon completing them they returned the dully filled questionnaires to the researcher. The questionnaire had questions which were designed gather data for analysis and to answer research questions.

3.5.1.2Interview schedule

This involved the use of standard questions to be asked to the respondents while the researcher or research assistants are filling the answers to the question. Research assistants were chosen from the university students residing in Busia County and were trained on how to undertake the study by the researcher. The advantage is that the researcher can choose only the right responses while leaving out any information that may not be relevant to the study. It also eliminates the problem of not responding usually common with use of questionnaires. It provides the researcher and the respondent's opportunity to discuss the importance of the study and this will assist in getting the respondents will to participate with confidence. Interview schedule was administered to key informants who included CEC health, Chief Officer Health, Health Director and Sub County administrators.

3.5.2 Secondary Data

Secondary data was collected from various literatures including books, articles, scholarly journals, dissertations, thesis reports, government policy documents and other articles deemed to be of relevance to the study. This method provided a pillar for the study because

of its factual and authoritative information on resource allocation, healthcare service delivery and competency of healthcare workforce.

3.6 Validity and Reliability

This section describes validity of an instrument which is the degree to which an instrument measures what it is intended to measure and reliability which is the likelihood that the research instruments will yield consistent results even after repeated tests.

3.6.1 Validity

To determine and improve the validity of the data collection tools, pilot study was carried out with a small number of questionnaires in Angurai Health Centre in Teso North Sub County. This allowed the preparation of the final questionnaire to be used for the study.

3.6.2 Reliability

Kothari (2004) states that the reliability of the questionnaires test refers to the ability of that test to consistently yield the same results when repeated measurements are taken of the same individual or phenomenon under study. According to this study, reliability therefore implies to the degree to which a research instrument yields consistent results or data after repeated trials. To test reliability, the researcher used the test re-test method by administering the same questionnaire to different groups.

3.7 Data Collection procedures

Data collection was done by use of structured questionnaires with open and close ended questions. Data collection instruments were prepared prior to going for data collection. This was done while considering the fact that data collection instruments had great implication on the validity of the study. Therefore, after the questionnaires had been tested

for reliability and accuracy a confirmation was done with the help of a researcher from the School of Arts Moi University. Interview schedules were prepared and administered to key informants with the aim of collecting key data on the study area. Relevant permissions to carry out this research were sought both from Moi University, Ministry of higher education and the relevant authorities in Busia County. Days for data collection were determined by the researcher with the help of a research assistant.

3.8 Data Analysis

The data was analyzed both quantitatively and qualitatively. Qualitative analysis was done on the information collected from the interview schedules. The study utilized SPSS to calculate the Percentages and values in its quantitative analysis. The data was analyzed quantitatively by the use of descriptive statistical techniques characterized by use of frequency, mean and standard deviation and inferential statistics in the form of Pearson's correlations and multiple regression analysis as represented by the formula below.

$$y = \alpha + \beta_1 (RA) + \beta_2 (HL) + \beta_3 (OS) + \beta_4 (WC) + e$$

Where the variables are defined as:

y: Service delivery

RA- Resource Allocation

HL- Health Leadership

OS- Organizational Structure

WC-Workforce Competence

e- Error term

3.9 Limitations of the Study

The study area was extensive with high populations and few healthcare institutions scattered far apart. This means that it was not easy to determine the right individual for the study. However, the researcher sampled a few people based on his experience and knowledge of the area. This County had also witnessed a good number of healthcare challenges which resulted in employees getting threats of losing jobs from the County Government out of poor performance. This prompted the employees not to answer questions for fear of victimization. The researcher however took the responsibility of informing them that the research was academic and was not meant to marline the image of the County whatsoever.

3.10 Ethical Considerations

During this study, ethical issues that could arise included authorization to conduct the study, acquisition of permits and informed consent of the respondents. Authorization letter was granted by Moi University and a research permit was granted by NACOSTI. It was also ethical to seek for the consent of participants willing to take part in the study. The research purpose and nature were openly revealed to the participants. Apart from these, the researcher ensured that the information from the respondents' remained confidential and their identities remained anonymous throughout. The researcher also ensured that the individual rights of respondents were safeguarded to avoid violations of basic human rights. All information obtained during data collection was treated with privacy and confidentiality.

3.10.1 Summary of the Chapter

This chapter dealt with research methods where it discussed the research design, target population, sampling techniques, sample size, data collection instruments, data analysis applied in the study. Ethical considerations were also discussed. The next chapter will be discussing how resource allocations influence healthcare service delivery.

CHAPTER FOUR

RESOURCE ALLOCATION ON HEALTHCARE QUALITY SERVICE DELIVERY

4.1 Introduction

This chapter deals with resource allocation and the influence it has in relation with healthcare quality service delivery in Busia County. The chapter is divided into sections based on the interviewees' opinions and the key informants who were interviewed. It starts with the respondents understanding of the term devolution which is key in the study. For this to be achieved, the chapter includes a look into the level of education of the respondents as they inform their understandings. Some of the characteristics of the respondents were therefore discussed in this chapter in relation to healthcare quality service delivery and the influence of health resource allocation on devolved healthcare quality service delivery in Busia County.

4.2 Response Rate

In this study, a total of 200 questionnaires were distributed to the targeted respondents. However, 106 of the targeted respondents gave their responses in all questions asked which was rated at 53.0%. According to Mugenda and Mugenda (1999), a response rate of at least above 50% is excellent which means that the research reached target was enough to represent deduced views of the general public.

4.3 Respondents understanding of the term devolution

The study was informed by key Busia County staffs in health sector that were critical in determining the influence of the effects of devolution on healthcare quality service delivery within the context of Busia County Government. There were 106 out of 200 respondents

who gave out their feedback comprising of county staff and Busia residents. Respondents were asked to give their understanding of the term devolution. In order to get views regarding the respondents understanding of the term devolution, it was found necessary to know the educational levels of the respondents as education enables understanding of dynamics. This is also because education is important for the acquisition of necessary skills and competencies for proper work.

In addition to the level of education, the study had to include the respondents' levels of experience because opinions vary depending on the participation or observation. The respondents were found to have served for varied number of years at their work stations at varied positions in the organization.

Table 4.1 Highest level of education attained.

Highest Level of Education	Certificate	Diploma	Only Degree	Degree plus Diploma (PGDE)	Masters	**Total**
Frequency	8	20	60	12	6	**106**
percentage	7.5	18.9	56.6	11.3	5.7	**100**

Source: Collected Data, (2018)

The findings show that majority of the respondents at 56.6% were first degree holders, followed by 18.9% who were diploma holders, 11.3% were degree and post graduate diploma holders, 7.5% were certificate holders and 5.7% were Master's degree holders. It was established that all the respondents were learned. It means that they had an understanding of variety of issues in relation to healthcare and in line with the term devolution.

Moreover, the educational level progression as indicated in the research findings implies that there had been efforts by the respondents to further their studies. As a result the respondents who had First Degree and above were more knowledgeable compared to the others. More so, we can infer that the respondents had a quest to further their studies and therefore become more suitable to the changing requirements of the job market. The fact that majority of the respondents had degree qualification and above implies that they were qualified to reliably answer questions about influence of effect of devolution on healthcare quality service delivery.

On work experience, it is evident that majority at 48.1% had worked for the public service for more than 15 years and 27.4% for between 10-15 years. This means that they were in service before the current Kenyan Constitution that introduced devolution. It was good having the experienced form part of the respondents because of their knowledge in centralized governance and now devolved units. Devolution has existed in different states but in Kenya it started after the year 2010 which means that several of the workers may have known it through studies but was also present during its practicality in Kenya.

With reference to working experience table 4.2 below shows the distribution of years of experience.

Table 4.2 Number of Years Worked Cross Tabulation

Number of years worked	**Below 5 years**	**5 - 10 years**	**10 - 15 years**	**Above 15 years**	**Total**
Frequency	12	14	29	51	106
Percentage	11.3	13.2	27.4	48.1	1**00**

Source: Collected Data, (2018)

The findings also showed that 13.2% of the respondents had work experience for between 5-10 years and 11.3% for less than 5 years. This implies that some of respondents started working when devolution had taken place in Kenya. Their levels of experience are a product of devolution and therefore had a better understanding of the devolution and its related components. This is in line with the expressions of Galbraith et al…, (1986) that the credibility of the information gathered in any study is informed by the many years of the respondents' service to the organization. The experience proves the validity and reliability of the information obtained. Their skills, knowledge and expertise had been tested for a long period hence their perception on the matter under study had been influenced by their experience.

In relation to the concept devolution, it was found out that all the respondents had at least an idea of what devolution is. One of the respondents stated that;

> *"Devolution is the transfer of resources from the National government to the regions where they are manned by the County Governments under the leadership of the Governor and their County Executives. It means that the County Government has to establish a good administrative structure to assist in offering different services one being health".*

Majority of the respondents talked of devolution as involving transfer of power and resources to the County levels. One of the interviewee was however critical in defining devolution as follows;

> *"Devolution in a professional understanding is the transfer of power from the central government to the lower tiers of government in which case is the County Government in Kenya. However, it has not been fully done in Kenya as power lies at the central government subjecting the County Governments to beg for the National Government through the Commission on Revenue Allocation to disperse resources on time making*

> *the transition difficult. Devolution should be a smooth transfer of power and resources to the local levels and reach all the citizens with equality".*

The respondents were able to link devolution with distribution of resources from the national government headed by the president to the Counties headed by Governors. Other key aspects found from the responses in line with the term devolution included delegation. Some of the respondents stated that devolution involves delegation of powers from the central point to the counties. One of the respondents was more specific and had the view that

> "Devolution derives itself from delegation whereby a single unit of government otherwise called 'central' would abandon some of the roles altogether to a more decentralized unit that understands better the needs and wants of its people. A closer one has been the municipalities where the councilors and the town clerks were closer to the people and understood their issues better and would be in a much better position to handle if empowered through resource allocation".

Devolution is understood differently according to the responses by the respondents. One of the interviewee stated that devolution is based on the country where practiced. An example cited is England where the interviewee argued that devolution is the transfer of power and funding from national to local government. Another interviewee highlighted that devolution plays a role of ensuring that decisions are made closer to the local people together with the communities and businesses they affect. Devolution can be said to provide much greater freedoms and flexibilities at a community, village or local level only if the agencies like Sub-Counties or Wards in the Kenyan context work more effectively to improve public services for their area.

Devolution according to the respondents' views would be more effective if the delegated public services are well utilized to ensure greater growth and stronger partnerships between

public, private and community leaders in local areas. To others, devolution should ensure decisions are reached at from the local level where the public understand better the challenges their communities face and possible best ways to overcome them.

4.4 Quality Service Delivery

The respondents were asked the questions on service delivery because the aim of any organization or agency is to ensure effective and efficient service delivery. This is based on various components like service strategy where the service provider sets the parameters in line with its desired service platform. Quality service delivery is determined by different strategies inclusive of performance, training and empowerment.

Quality is seen as the highest level of service provision that can be best received by customers within and outside the stipulated scope of the organization. Quality is interlinked with management which is a process of continuous improvement through which everyone strives to create and support an environment in which people are committed to serving and meeting the needs of the clients.

The service users judge the quality of services in terms of the satisfaction levels and the ability of the service to solve the problem at hand. On the other hand, the service benefit by the community members is based on the ability to empower the locals hence the need to involve the society in improving the services offered to them.

This part used SERVQUAL model to get expectations of respondents using a seven-point Likert scale ranging from “strongly disagree=1” to “strongly agree=5” to measure the 20 items. There were variation of the responses based on the respondents’ views, understanding, opinion, perceptions among others as shown in tables 4.2 and 4.3.

Table 4.3 Average SERVQUAL Scores of Staff Expectations and Perceptions

Dimension	Item	Perception	Expectation	SERVQUAL Score
Tangibility	1. Excellent Busia County Health Institutions has modern looking equipment	4.87	5.61	-.744
	2.Excellent Busia County Health Institutions physical facilities are visually appealing	5.04	5.62	-.577
	3.Excellent Busia County Health Institutions reception desk employees are neat in appearance	4.88	5.48	-.599
	4.An excellent Busia County Health Institutions receipts, cheques and similar materials are visually appealing	5.56	5.57	-.013
Reliability	5. When an excellent Busia County Health Institutions promises to do something by a certain time, it does so	5.57	6.06	-.489
	6. When patients have problems employees in an excellent Busia County Health Institutions will be sympathetic and reassuring	5.42	6.02	-.621
	7. An excellent Busia County Health Institutions performs the service right the first time	5.45	6.15	-.692
	8. An excellent Busia County Health Institutions provides its services at the time it promises to do so	5.37	6.03	-.665
	9. An excellent Busia County Health Institutions insists on error-free records	5.63	6.27	-.634
Responsiveness	10. Employees in an excellent Busia County Health Institutions tell exactly when the services will be performed	5.45	5.98	-.533
	11. Employees in an excellent Busia County Health Institutions give prompt services.	5.26	5.88	-.612
	12. Employees in an excellent Busia County Health Institutions are always willing to help patients	5.04	5.63	-.590
	13. Employees in an excellent Busia County Health Institutions are never too busy to respond to patients questions	5.07	5.50	-.427
Assurance	14.Employees in an excellent Busia County Health Institutions instill confidence in patients	5.34	5.96	-.626
	15. Employees in an excellent Busia County Health Institutions always respect patients.	5.52	6.11	-.590
	16. Employees in an excellent Busia County Health Institutions have necessary knowledge to answer patients' questions.	5.21	5.91	-.699
Empathy	17. An excellent Busia County Health Institutions gives patients individual attention	4.87	5.73	-.859
	18. An excellent Busia County Health Institutions has working hours suitable for all patients	4.47	5.19	-.718
	19. An excellent Busia County Health Institutions has patient's best interest at heart	4.55	5.40	-.855
	20. The employees of an excellent Busia County Health Institutions understand supplier specific Needs	4.53	5.35	-.824

Source: Collected Data, (2018)

The 20 sets (pairs) of statements were designed to fit into the five dimensions of service quality. A seven-point scale ranging from “strongly agree” (7) to “strongly disagree” (1) accompanies each statement. The “strongly agree” end of scale is designed to correlate with high expectations and high perceptions. Service quality occurs when expectations are met (or exceeded) and a service gap materializes if expectations are not met. The gap score for each statement is calculated as the perception score minus the expectation score. A positive gap score implies that expectations have been met or exceeded and a negative score implies that expectations are not being met. Gap scores can be analyzed for each individual statement and can be aggregated to give an overall gap score for each dimension (Parasuraman et al.., 1988).

The findings from the above table shows that SERVQUAL scores for all items bear negative signs meaning that expectations are greater than perception, then perceived quality is less than satisfactory and a service quality gap materialized. For instance, the findings indicate that people in Busia County expected the healthcare institutions to have modern looking equipment whereby on expectations 5.61 based on the Linkert scale agreed. However, this has not been the case on the ground. The expectations have not become a reality yet as the county government is still putting up to ensure quality healthcare service delivery is realized in Busia County.

Moreover, the perception and expectation levels of the respondents were similar about the excellent Busia County health institutions physical facilities being visually appealing. The expectation and perceptions are high at 5.04 and 5.62 respectively. This implies that the public have expectations that resources allocated at the County government should yield positive results. The residents of Busia from the findings have high expectations that the

County government should be able to fulfill health pledges and promises at the stipulated time. However, the SERVQUAL scale is at -.489 which implies that the perceptions and expectations of the public are high but the level of accomplishments by the authorities are low and the study attributes this to the fact that healthcare as a function is still new to county governments and the county government is still aligning itself to it as resources to operationalize it is still under the central government and this confirms the postulation of Bossert,(1998) Principal Agent theory that view the national government as an principal actor controlling functions of devolved systems of government.

As per the findings, people expect the County governments to provide services at the time it promises to do so. They see this as the reason for devolution making services reach to the local level. This according to the findings is not the case as the service may not be rendered as promised by the service provider. The expectations therefore are high but the outcome turns to be much lower hence creating a perception from the service clients.

The perceptions of the respondents from the finding inform the expectation and once the outcome are far below the expectations, perceptions become negative. For instance, people in Busia County expect the employees in the health institutions never to be too busy to respond to patient's questions and instill confidence on their patients. This is used by the same clients to rate the quality of the services rendered which are influenced by perceptions versus expectations.

Research conducted, are of the sort that support SERVQUAL scale. Common results of the relevant researches can be summarized as such, that, perceived service quality is the result of comparison of service performance with patients expectations and the evaluation of service quality does not only depend on final output but also on the way of how the service

is provided . That is why from the findings the respondents have the view that Busia County health institutions should be patient oriented putting the patient need at the core and should understand the supplier specific needs. This result further agrees with Lau et al…, (2011), who argued that service gaps was common and negative SERVQUAL scores were the order of the day particularly in the Busia County Health Institutions where the perceptions and expectations of both patients and staff, often similar, showed that there was no quality service delivery in the Busia County Health Institutions.

Table 4.4: SERVQUAL Scores of Quality Dimensions

Dimensions	**N**	**SERVQUAL Scores (Average)**	**Sig. (p)**	**Relative Importance (Weights) of Quality Dimensions stated by Staff (%)**	**Weighted SERVQUAL Score**
Tangibles	106	-.64000	.007	16.77290	-0.10734
Reliability	106	-.62020	.000	27.62948	-0.17135
Responsiveness	106	-.54050	.001	20.18326	-0.10909
Assurance	106	-.62850	.000	20.27490	-0.12742
Empathy	106	-.83720	.000	15.13944	-0.12674
Total un-weighted SERVQUAL score		-.65328			
Total weighted SERVQUAL score					-0.64197

Source: Collected Data, 2018

Table 4.3 shows SERVQUAL scores presented in line with five dimensions. These dimensions include tangibles, reliability, responsiveness, assurance and empathy. Based on the quality dimensions, empathy has the highest negative SERVQUAL scores at -.859. The reason why empathy level was at its lowest is because it is associated with an individual

and touches on oneself. Empathy touches on individual attention expected by a client when they visit any of Busia County healthcare institutions. It is assessed by people on the basis of health institutions working hours in suitability of all clients which is expected to be to the best interest of the client. In other words, compared with other factors, satisfactory level of empathic behavior is lower.

In regards to the quality improvement, the most important dimension to which highest rating (27.63 percent) is assigned is reliability. Reliability is determined by the quality of being trusted and the ability to perform well over a longer period of time. Reliability is reliant to accuracy levels of the services rendered by the health institutions. This is measured by the level of employees at Busia health institutions being sympathetic and reassuring. This dimension is followed by assurance and responsiveness respectively. In this respect, empathy having the highest negative SERVQUAL score is the least important dimension. When the relative importance of quality dimensions as weights are considered, highest negative SERVQUAL score passed from empathy to reliability. Furthermore, the difference between total weighted SERVQUAL score (-0.64197) and total un-weighted SERVQUAL score (-.65328) do not seem noteworthy. Again, this is agreed to in literature of Sohail, (2007) who in his studies found that empathy had the lowest negative rating in the Health Institutions because he argued, empathy was characterized more by psychological and emotional needs to which public servants were unwilling to engage with when it came to customer interaction.

4.5 Resource Allocation and Quality Service Delivery

For any service to be effectively rendered, resource allocated plays a role. Resource allocation is giving assets to be under care of an entity or an individual to be well managed

and properly utilized in order to attain a goal. The assigned assets should support the strategic goals of the organization. Table 4.5 below shows resources allocated to healthcare services in Busia County from 2013 to 2018.

Table 4.5 Resources Allocated to Healthcare in Busia County.

Activity		**Personnel emolument**	**Operation & Maintenance**	**Development**	**Total**
Financial	2014/2015	Ksh782,004,244	Ksh328,760,260	Ksh390,456,437	**Ksh1,501,220,941**
Year	2015/2016	Ksh832,886,817	Ksh136,380,514	Ksh589,571,047	**Ksh1,558,838,378**
	2016/2017	Ksh957,575,498	Ksh397,481,298	Ksh353,331,761	**Ksh1,708,388,557**
	2017/2018	Ksh1,128,258,435	Ksh416,538,557	Ksh293,573,967	**Ksh1,838,370,959**

Source: BUSIA CG CIDP, (2018)

It was necessary to find out the relationship between resource allocation and quality service delivery. The respondents were asked their opinions in relation to this as resource allocation includes managing tangible assets in order to make better use of human capital and ensure effective service delivery. It was therefore necessary to get the respondents views as organizations must be driven by the desired end goal prior to determination of the resource allocation.

The researcher sought to assess the resource allocation influence on healthcare quality service delivery. The findings were as shown in the table below.

Table 4.4Resource Allocation and Quality service delivery in healthcare

Statements	VGE		GE		M		LE		NA		Mean	StD
	C	%	C	%	C	%	C	%	C	%		
To what extent does the availability of resources required, (physical Financial and human facilities) support the Quality service delivery in healthcare?	12	11.3	65	61.3	3	2.8	17	16.0	9	8.5	3.42	.712
To what extent do the financial systems and procedures established by the organization support Quality service delivery in healthcare?	9	8.5	65	61.3	5	4.7	21	19.8	6	5.7	2.55	1.09
To what extent does the county maintain financial management systems to ensure proper utilization of funds, accountability, financial monitoring and efficient reporting, all geared towards Quality service delivery in healthcare?	9	8.5	66	62.3	5	4.7	19	17.9	7	6.6	2.03	.909
To what extent do resources get allocated optimally for the sake of minimizing production costs and creating added value for the outputs?	11	10.4	60	56.6	7	6.6	22	20.8	6	5.7	2.48	.809
To what extent does IT get utilized for standardization of operations and lowering cost for effective County based healthcare quality service delivery?	9	8.5	18	17.0	5	4.7	64	60.4	10	9.4	2.32	1.35

Source: Collected Data, (2018)

From the findings as shown in table 4.4, it is clear that 11.3% of the respondents said that to a great extent the availability of resources required whether physical, financial or human supported the Quality service delivery in health care. This implies that availability of resources required, (physical, Financial and human facilities) was very important if healthcare was to be effectively implemented. A majority 61.3% of the respondents were of the idea that the availability of the required resources in a health institution is to a great extent important in ensuring proper service delivery. Human resource for example are able to deliver their duties and offer services effectively if the resources are at hand like the social media platforms are therefore considered part of a modern organizations service delivery program. The availability of the tools like the management tools can help identify areas of service delivery which explains a few of the respondents 3.42% did not agree with the assertion that availability of required resources support the quality service delivery in health care.

The findings were in agreement with the assertions by Tregue and Tobia, (2009) who observed that a project is presumed to be realistic if the required resources are available. The allocation represents management commitment to the plan of action. This study links the allocation of resources as the availing of material and human resources required for the Quality service delivery in healthcare. Pearce and Robinson (2007) have seen the annual budget as the main vehicle for resource allocation.

When asked to what extent the financial systems and procedures established by the organization supported Quality service delivery in healthcare, 61.3% said to a great extent. The reason is attached to the money economy where most of the things carried out are based on money as corroborated by fiscal allocations of the county annually. Some of the

respondents 19.8% said financial systems established by the organization to a little extent support quality service delivery in health care. However, as the researcher is of a contrary opinion that the financial structures in place have a great role in relation to quality. For instance releasing money for certain resources to be added by the organization may not be well utilized if the structures are not properly instituted. Some of the respondents translating to 4.7% were moderate. This implies that financial systems and procedures were necessary components of Quality service delivery in health care. Pearce and Robinson (2007) have seen the annual budget as the main vehicle for resource allocation. Thompson and Strickland (2006) on linking the budget with strategy mean providing enough of the right people and funds. Too little will not be enough and too much is waste. Implementing teams must be deeply involved in the budget process with such budgets being flexible enough to take into account evolving changes.

The principal Agent theory underscores the importance of decision space in making financial decisions, it argues that key decisions on sources of revenue and allocation of expenditure are likely to have significant influence on equity and financial soundness, although the theory acknowledges that some allocation decisions about the organizational structure of services are also likely to have an important impact on efficiency, quality and equity in service delivery, enough resource allocation is key towards quality service delivery.

The respondents were further asked the extent to which the county maintained financial management systems to ensure proper utilization of funds, accountability, financial monitoring and efficient reporting, all geared towards Quality service delivery in healthcare. Majority 62.3% said to a great extent. This implies that financial systems and

procedures were necessary components of Quality service delivery in healthcare and this finding has already been supported by literature. There are however some loopholes where the county funds are misappropriated and not utilized as intended as maintained by 17.9% who argued that maintenance of county financial management systems are not intended to ensure quality service delivery but rather to benefit a few county executive individuals.

The respondents were also asked the extent to which resources are allocated optimally for the sake of minimizing production costs and creating added value for the outputs. From the findings, a few respondents constituting 10.4% said to a very great extent while majority 56.6% said to a great extent. However, the two categories of respondents were in agreement except for the level. Resources are normally added if they can add value to the organization in terms of increasing the general output. There were 6.6 % who were moderates while 20.8% to a little extent. This implies that the allocation of optimal resources added value to the county Healthcare quality service delivery. Alexander (2005) argued that an organization seeks to allocate its resources optimally for the sake of minimizing production costs and creating added value for the outputs. To implement this, management chooses a combination of structure, control, and culture compatible with lowering its cost structure while preserving its ability to attract customers. In practice, the functional structure is the most suitable provided that care is taken to select integrating mechanisms that will reduce communication and measurement problems.

Finally, when asked generally, to what extent IT got utilized for standardization of operations and lowering cost for Effective County based healthcare quality service delivery? Majority 60.4% said to a little extent. This is because the county government has not enabled the public to access some of the health services online such as inquiries.

Another 17.0% said to a great extent and 4.7% were moderate. This implies that there was no effective use of IT to lower costs and ensure that services are offered professionally. This is considering that IT is important.

4.6 Summary of the Chapter

This chapter discussed the findings on the influence of resource allocation in quality health service delivery. It also analyzed the response rate of the respondents and their understanding on how resource allocation influences health service delivery in Busia County. The next chapter will be discussing how health leadership influences healthcare quality service delivery.

CHAPTER FIVE

INFLUENCE OF LEADERSHIP ON HEALTHCARE QUALITY SERVICE DELIVERY

5.1 Introduction

This chapter deals with the findings on the influence of health leadership on devolved healthcare quality service delivery in Busia County. It starts by discussion of the views from the respondents about the actors involved in devolution of healthcare sector in Busia County. Another area covered in this chapter is on the roles of the actors involved in the devolution of healthcare sector in Busia County. The findings are related to the literature review together with the views from the researcher.

5.2 Actors involved in Devolution of Healthcare Sector in Busia County

There are several Actors involved in the devolution of healthcare sector in Kenya. The National government has been in charge of the health through the Ministry of Health. However, with devolution taking place, the health sector has been delegated to the County Government which has come with its positives and negatives.

From the findings, all the respondents' agreed that they know of actors involved in devolution of healthcare sector in Busia County. The results with respect to respondents' opinions on the actors are as follows.

Table 5.1 Respondents views on Actors

Number of Respondents	Stated Actors	Percentage (%)
32	Ministry of Health	30.19
27	Private Sector	25.47
20	Public Sector	18.87
18	Individuals	16.98
9	(Volunteers) Development Partners	8.49
106		**100**

Source: Collected Data, (2018)

From the findings, majority 30.19% of the respondents were aware of the Ministry of health as an actor in healthcare sector. There were different opinions from the respondents as to why they thought of the various actors. One of the respondents' argued as follows;

> "The Ministry of health is the main actor of healthcare because it existed even before devolution. Ministry of Health has a great role of policy formulation on how best the healthcare services can be offered. Without good policies, there will be a weak link and unclear roles of the healthcare service providers between those devolved and those under the National government which can easily lead to conflicts. At the end will be low service delivery and many other disruptions that will result from the same".

Several of the respondents were able to state that the MoH is under the national government and plays a great role in ensuring there are resources. The reason why majority of the respondents stated MoH as an actor is because of its long term role as a central government entity of health. It has been in charge of coordination of healthcare facilities

and service provision for years. To date, some of the citizens' associate health matters to the ministry because they do not have knowledge about devolution of health. Others understand devolution but have not had a clear cut difference between the healthcare quality service delivery mandates at the national and county governments.

Another category of the respondents of 25.47% were able to state the private sector as an actor in healthcare quality service delivery in Busia County. In this group of respondents sharing the same idea, private hospitals emerged as among the many private entities that assist in offering healthcare services. Others categorized the services offered by private healthcare institutions as among the best. There was this response from one of the respondents;

> *"The faith based healthcare institutions assist very much in complementing other private and government of Kenya health institutions. They provide health services that are satisfactory with some of them located in the remote areas where the government ones are few".*

There are those private hospitals that provide quality health services though they are known to be very expensive and not affordable to many. However, some of the respondents stated some of the private sector institutions roles like the USAID role in healthcare service provision. There are several other private institutions that have assisted the rural dwellers in meeting their healthcare needs by assisting clear their medical expenses or playing a partial role. The Kenya Red Cross Community was mentioned by the respondents as a non-profit organization that comes into the rescue of life through their first aid kit and their ambulances that supplement the county government, national government and other private institutions in facilitating transportation.

Apart from the ministry of health the public institutions was affiliated to the responses of 18.87% of the respondents as the key actors in devolved healthcare quality service delivery. Health sector facilities are meant to assist the public. This makes public as the key player in shaping the healthcare services they receive. One of the respondents' highlighted as follows;

> *"The public facilities provide public health services to the population which is their main mandate. The county government coordinates and implements quality improvement activities in order to ensure that services provided are of high quality".*

The public and the MoH are linked because the Ministry cannot operate without the public. The opinions and views of the public play a great deal in influencing the direction that policies take. Good policies are those that align themselves to bettering services received by the intended clients. In the health sector whether private or public, they are oriented towards the clients and good policies should better the outcome. The public can shape healthcare services whether through forums, suggestions or in the court of public opinions others taking the direction of public outcry.

The principal Agent theory element of decision space approach stresses the importance of governance rules in influencing the role local political actors, beneficiaries and providers that play important role in making local decisions. These rules structure local participation in a decentralized system and influence policy making in public institutions. This assumption of the theory is linked to the findings of this study.

From the findings, 16.98% of the respondents stated that individuals are actors to the healthcare service provision. This may have been informed by the idea that individual

initiatives can assist in a wider perspective. A key respondent was aware of the roles played by individuals that make them important in healthcare sector. The argument was as follows

> *"Individuals are key in providing areas for reforms. There are those who volunteer to assist in the health sectors through their willingness to provide services without pay. Health volunteers have assisted in the rural where health officers cannot reach in activities including awareness creation on causes of some diseases like cholera outbreak and spread of HIV disease".*

Several of the county hospitals have included health volunteers who work with the local doctors and nurses to provide services. Some of the services include child birth services and their related complications and in some instances breaking the language barrier. Individuals are responsible for ensuring care and support for their families and the communities they live in. A least group of the respondents of 8.90% said that development partners are important actors in the healthcare sector. The developments partners are well known for their activities of ensuring resources are available. The development partners provide technical assistance. For the development partners to be there, the leadership and health systems are very critical. Leadership in the healthcare quality service delivery is about overseeing and guiding the whole healthcare system.

The political and technical action is required in the healthcare system because of the continued change in competing demands and resources. The arising issues of corruption have to be dealt with in the health sector because they interfere with service provision. The actors in government and those outside government like the civil societies do influence action and key determinants of health and the access of offered health services. The respondents touched on several issues affecting the actors. One of the factors stated is the poor management of healthcare facilities brought about by devolution of healthcare even

though it was in existence before the devolution. The frequent strikes witnessed are part of the mismanagement.

5.3 Health leadership on Quality service delivery in healthcare

Healthcare stewardship is the key component in determining successes and effectiveness of healthcare sector. Health system leadership starts from the national government to the devolved unit. It includes the guiding and overseeing of the whole health system from public to private. The focus here is ensuring public interest is met.

Healthcare leadership need to have clear strategies and well framed policies. If this is put in place, there will be clear goals, directions and spending priorities. Collaboration is key and the regulations and incentives if well formulated will better service provision from the national to the local levels. The need for greater accountability arises from the growing demand to demonstrate results. Accountability in healthcare leadership is an intrinsic aspect of governance that concerns the management of healthcare relationships between various stakeholders in healthcare system including individuals, communities, governments, nongovernmental organizations, private firms and other entities that have responsibility to finance, monitor, deliver and use healthcare services.

In order to get the views from the respondents on influence of leadership on quality service delivery in healthcare, questions were asked measured using a Linkert scale. The responses ranged from SA for Strongly Agree; A for Agree; N for Neutral; D for Disagree; and SD for Strongly Disagree.

The responses were as shown in table 5.2.

Table 5.2 Influence of Health Management Structure on Quality Service Delivery in Healthcare

Statements	SA		A		N		D		SD		Mean	StD
	C	%	C	%	C	%	C	%	C	%		
Employees need to be supervised closely, or they are not likely to do their work.	9	8.5	66	62.3	6	5.7	18	17.0	7	6.6	2.42	.612
Employees want to be a part of the decision-making process	8	7.5	64	60.4	7	6.6	19	17.9	8	7.5	2.65	1.00
In complex situations, leaders should let subordinates work problems out on their own.	7	6.6	60	56.6	8	7.5	22	20.8	9	8.5	2.53	.949
It is fair to say that most employees in the general population are lazy.	6	5.7	20	18.9	5	4.7	70	66.0	5	4.7	2.40	.849
Providing guidance under pressure is the key to being a good leader.	8	7.5	20	18.9	7	6.6	67	63.2	4	3.8	2.62	1.05
As a rule, employees must be given rewards or punishments in order to motivate them to achieve organizational objectives.	6	5.7	63	59.4	8	7.5	19	17.9	10	9.4	2.72	.949
Most workers want frequent and supportive communication from their leaders.	12	11.3	65	61.3	3	2.8	17	16.0	9	8.5	3.41	.702
Most employees feel insecure about their work and need direction.	9	8.5	65	61.3	5	4.7	21	19.8	6	5.7	2.23	1.24
The leader is the chief judge of the achievements of the members of the group.	10	9.4	64	60.4	5	4.7	18	17.0	9	8.5	2.42	1.88
It is the leader's job to help subordinates find their "passion."	9	8.5	66	62.3	5	4.7	19	17.9	7	6.6	2.11	.943
Effective leaders give orders and clarify procedures.	11	10.4	60	56.6	7	6.6	22	20.8	6	5.7	2.56	.845

Source: Collected Data, (2018)

From Table 5.3, it is evidently clear that majority at 70.8% agreed that employees needed to be supervised closely, or they were not likely to do their work. From those who agreed, 8.5% strongly agreed that the employees need to be closely supervised. Their believe is based on close monitoring. One of the respondents had the following opinion;

> *"If productivity is to be high in terms of efficient service delivery, health sector in Busia County and generally across the country must develop a mechanism that employees are closely monitored day by day".*

The other 62.3% of the respondents only agreed that there should be close supervision of employees. They believe that employees should be closely monitored if they have to meet strict deadlines and ensure health services are offered in time. One of the respondents sharing the opinion explained as follows;

> *"A manager or a supervisor is liable in case services are not offered to the expected standards by the receivers of the service. Without close supervision, some of the workers will relax and would not work towards the best but when they are under watch, they will do everything to satisfy the client".*

Many people tend to do things their own way but if they are monitored, they can be corrected by the supervisor. Since the manager has the role and responsibility of coaching, training and ensure proper employee development, they have to closely monitor their employees in order to understand their strengths and weaknesses. Supervision opens room for understanding of the employee and in line with categorizing them in the service areas where they will perform to the highest possible standard.

The findings showed that 5.7% of the respondents were neutral. It means that they had the opinion that employees once trained and informed of their roles are supposed to implement forthwith. However, the argument expressed is that the level of supervision can be there but at a minimal level.

Only 23.6% disagreed because they believe that employees should be provided with clear roles which they have to follow and be guided in their daily chores. One of the respondents stated that

> *"Any employee should be well trained and training to be made a continuous process because of the changing environment. If they are well equipped, employees should be able to deliver without daily and close monitoring".*

They however agreed that monitoring should be there but not closely because close supervision creates tension among the employees to the extent of creating a not so conducive environment. This implies that the leadership style had some form of authority that was neither transactional nor transformational. This is agreed to in literature where leadership gurus argue that there is need for shared values to avoid close supervision which is always stifling (Hill & Jones, 2010).

When asked if employees wanted to be a part of the decision-making process, 67.9% agreed. All inclusive decision making is important in that it allows employees expression of how the health sector can improve its service provision. Since healthcare actors are many in the society, the county government may not be able to clearly meet with each. However, there are some of the employees who through their service provision in the health sector interact with them. If such employees are given an opportunity to participate in decision making, they add value to efficiency in decisions made. People have different ideas only that some do not get the opportunity because all cannot be employees. Allowing the employees to participate in decision making process will allow they feel part of the process which will make them own and implement wholeheartedly the decisions arrived at.

There were 25.4% of the respondents who disagreed. They believe that decisions should be top-bottom where the managers are the ones responsible for ensuring proper healthcare systems have policies and are implemented. One key respondent stated that "the managers and supervisors are responsible for the successes or failures of the employees under their watch". It means then that they have to make all decisions that have to be practiced and implemented by the juniors. Those who were neutral were at 6.6%. The respondents' believe that decisions can be both top-bottom and bottom-up depending on the situation and circumstances. They believe that there are those moments when the supervisor has to make decisions like those touching on individual employees. There are also times when a supervisor has to make radical decisions but at some point they have to listen to the views from the service beneficiary which is through the employees. On how best to improve the health services, the supervisor can listen to the best decision practices from the employees. This gives an indication of the relevance of participation in decision process in creating quality implementation. Hargreaves, (1994) highlights the importance of creating opportunities for individual voices to be heard in collaborative endeavors while Fullan, (1997) points out that reform often misfires because we fail to learn from those who disagree with us.

On whether in complex situations, leaders should let subordinates work problems out on their own, 63.2% agreed. One key respondent explained why the agreement is high as follows;

> *"Employees in complex situations do all they can to find a solution. It creates room for them to create new ways of solving the problem. In a case where the supervisor intervenes, he or she will have killed the possible alternatives from the employees".*

However, 29.3% disagreed. Allowing the employees to work out on their own downs their morale and they fill neglected and not part of the institution. Instead, in complex situations, the institutions through the various line supervisors can create groups to work it out. This will encourage sharing of ideas that creates a long term and among the best solutions. A few 7.5% were undecided. It implies that the health institution when faced with such a situation can use both ways of allowing the employees to work the problems out on their own and thereafter create groups where they share the derive solutions. This gives an indication that the employees wanted transformational leadership. The virtue of these shared values and common culture is that they increase integration and improve coordination among organizational members. Similarly, rules and procedures and direct supervision are less important when shared norms and values control behavior and motivate employees. In addition, when organizational members buy into cultural norms and values, they feel a bond with the organization and are more committed to finding new ways to help it succeed (Hill and Jones, 2010).

When the respondents were asked if most employees felt insecure about their work and needed direction, 70.7% disagreed. A key respondent who disagreed strongly stated as follows;

> *"Employers carry out their employment based on the need to have certain human resource that they lack or to supplement the existing workforce. The employee is normally provided with duties and roles they have to carry out. It needs trust from the employer and since the process is tough, the employee is always the best. They should be given room to perform without interference".*

The findings indicate that 24.6% agreed employees should be provided with direction regularly because they should be under supervision in carrying out their daily activities.

The assumption is that employees are by nature lazy and if left unmonitored, performance declines. Among them, 4.7% were undecided. The few were of the opinion that employees need not be closely monitored but at some point are to be supervised in order to allow room for them to carry out their roles effectively. This implies that the staff felt they were adequately qualified to handle the job and could do the work on their own. Galbraith and Kazanjian (2006) argue that the top management is essential to the effective implementation of service quality change. Top management provides a role model for other managers to use in assessing the salient environmental variables, their relationship to the organization, and the appropriateness of the organization's response to these variables. The management also shapes the perceived relationships among organization components and once such has been achieved, qualified staffs do not need too much direction anymore.

The respondents' were asked whether providing guidance under pressure is the key to being a good leader. From the findings, majority 67.0% of the respondents disagreed. Those who had the opinion stated that a good leader should not put pressure to the employees because they will not be working in freewill which will interfere with their morale and motivation. On the other hand, 26.4% of the respondents agreed that a good leader should provide guidance under pressure. One of the key respondents stated as follows;

> *"Providing guidance under pressure increases organizations expectation and enables the employees to understand their responsibilities and those of their managers to the patients, colleagues and even themselves".*

Such a time that creates pressure assists employees to understand the situations and how they should be documenting risks and other concerns. A few 6.6% of the respondents were neutral. Pressure according to some, creates tension and may lead to mistakes. However,

taking things normal will lead to low output especially in a health environment where most activities touch on patients.

Majority 65.1% of the respondents agreed that employees must be given rewards or punishment in order to motivate them achieve organizations objectives. Rewards and punishments are the basic tenants of motivation. Rewards motivate because it shows that the employee accomplished something in a much better way that supports the objectives of the institution. Reward is therefore desirable because they can have both short-term and long-term desirable benefits. On the other hand, punishments may make the employee to work harder to complete their tasks. Employees may react to unexpected punishments by increasing performance. Punishment is however not the best way to increase production and performance because they create fear, anxiety and frustrations which can contribute to a negative work culture. The results further showed that 27.3% disagreed with the idea of rewards and punishments. They agree that while rewards and punishments can lead to good behaviors trained towards organizational success, they should not be made as a rule. Once it is taken as a rule, demotivation gets in which may lead to decline in quality service delivery. The 7.5% who were neutral may have been guided by both positive and negative consequences of rewards and punishments.

The findings showed that majority 72.6% of the respondents agreed that there should be supportive communication from the leaders. This creates an environment that is accommodative and makes the employees to feel linked to the management. One of the respondents stated that “supportive communication makes the employees feel secure that the management agrees with the services they provide”. However, 23.5% disagreed with the idea with 2.8% neutral. This implies that for quality service delivery to be achieved

there should be criticism of employees. At some instances, what the organization feels to be wrong should be corrected even if it does not concur with the opinions of the majority employees.

Majority 69.8% agreed that most employees feel insecure about their work and need direction. Similarly, that the leader is the chief judge of the achievements of the members of the group. This means that majority of the employees feel insecure of their work which is an aspect that reduces quality. The employees have to be well trained in order to avoid relying on the leaders. The respondents feel that the leader is in full control which may create biasness when making some decisions. The data indicated that 25.5% disagreed that most employees feel insecure of their work and need direction. It implies that employees are always trained and have the skills required carrying out a function. The same respondents disagreed that a leader is the chief judge of the achievements. It means that a success in an organization is a collective responsibility and such leaders should not take achievements to be upon themselves to decide. There was however 4.7% respondents who were neutral. This implies that management exercised power often to offer change needs in situations of emergencies and shortages in resources. This involves imposition of change or the issuing of edicts about change. It is the explicit use of power and may be necessary if the organization is facing a crisis. This style may be useful in crisis situations or rapid transformational change (Olson, 2005). Other strategies include use of power to bring about quality service delivery. Quality service delivery can be implemented in situations where the implementers possess some form of power. According to Bowman (1974), power strategies are used in situations where the change must be implemented quickly.

When asked if generally, it is the leader's job to help subordinates find their "passion", 70.8% agreed. It means that some employees agree that leaders should be motivational and should have the capability of identifying each employee's strengths and weaknesses. If they do so, they will focus on individual strengths and improve their weaknesses making the employees to realize their areas of interest. This leads to improved quality service delivery especially in the health sector. The data further indicated that 24.5% disagreed and 4.7% were undecided. This implies that, basically, the staff also wanted some form of transformational leadership to help them implement the quality service delivery better. Transformational leaders are more concerned about the passion and voluntary commitment of the employees to help them implement quality service delivery better.

When asked if effective leaders gave orders and clarified procedure, majority at 72.6% agreed, 24.5% disagreed and 2.8% were undecided. This implies that positively, the managers gave direction and clarified what needed to be done and how it was to be done. This is an example of a combination of transactional and transformational leadership which is good for Quality service delivery in healthcare. Further literature attests to this as according to Kaplan et al …, (1996), the strategic managers are involved in the design of information systems for the organization. In this role, managers influence the environmental variables most likely to receive attention in the organization. They must also make certain that information concerning these key variables is available to affected managers. Top-level managers must also provide accurate and timely feedback concerning the organization's performance and the performance of individual business units within the organization. Organization members need information to maintain a realistic view of their

performance, the performance of the organization, and the organization's relationship to the environment.

5.4 Summary of the Chapter

This chapter discussed the findings on the influence of health leadership on healthcare quality service delivery, actors in healthcare sector Busia County was also discussed. The next chapter will be handling the findings on organizational structure and its influence on healthcare service delivery in Busia County.

CHAPTER SIX

ORGANIZATIONAL STRUCTURE INFLUENCE ON HEALTHCARE QUALITY SERVICE DELIVERY IN BUSIA COUNTY

6.0 Introduction

This chapter deals with the influence of organizational structure on devolved healthcare quality service delivery in Busia County. The chapter is divided into sections based on the interviewee's opinion and key informants who were interviewed. It begins by discussing the effects of organizational structure on healthcare quality service delivery in Busia County. It also examines the organizations structure that supports healthcare quality service delivery. Other areas of concern in the chapter are the alignment of organizations structure to the central government. The respondents expressed their opinion and views on the extent to which devolution has affected the implementation of quality healthcare service delivery in Busia County.

6.1 Effect of Organization Structure on Healthcare Quality Service Delivery

The third objective sought to establish how organizational structure adopted by the County Government of Busia influenced the realization of efficiency in healthcare quality service delivery. The integrated health services in Kenya today is aligned to the management and delivery of quality and safe health services. It is determined to ensuring that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, through the different levels and sites of care both at the County and National government.

The theory used in this study looks at various functions and activities over which local authorities will have increased choice. It looks at decisions in selected functional areas. According to the theory, decisions in these areas are likely to affect the systems performance in achieving the objectives of equity, efficiency, quality and financial soundness. In this case, decisions made regarding functional areas could affect delivery of healthcare either positively or negatively and thus organizational structure have a role in influencing quality service delivery.

Under devolution, the overall leadership of the Health Departments in county governments is under the County Executive Committee Members (CECMs) who are responsible for the policy and representation of the department in the County Executive Committee.

The Chief Officer is the accounting officer for the financial and human resources. The consultative management of the Department is vested under the County Health Management team (CHMT) with the County Director of Health (CDH) as the chairman. The CHMT is constituted by heads of various professional cadres. The Department comprises of three directors namely Curative Health Service, Universal Health Coverage and Promotive and Preventive Health Services.

The Sub County Health services are managed by the Sub County Medical Officer of Health (SCMOH) who leads the Sub County Health Management Team (SCHMT) composing of health administrative officers, nurses and clinicians at the Sub County level. Busia County Referral Hospital is led by a medical superintendent while the other Sub County hospitals are led by medical officers. The hospitals have Hospital Management Committees Teams (HMT) and Hospital Management Committees (HMC). The Hospital Management Committees Teams includes heads of clinical departments, nursing officer in charge, ad

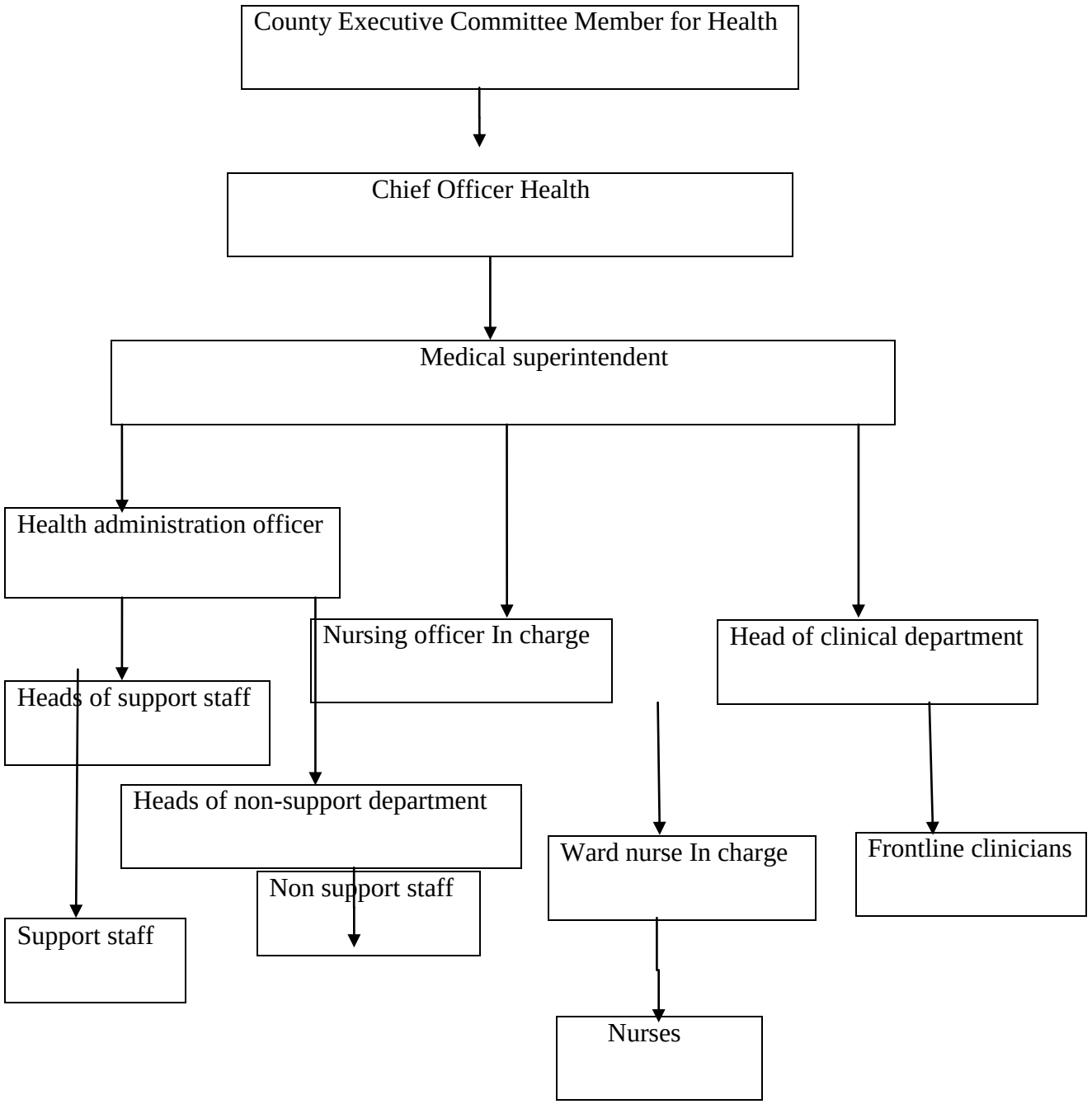
health administrative officers who oversee the daily health service delivery in their areas of jurisdiction. Figure 6.1 below presents organogram of Busia County Health structure.

Although under section 15 of the Sixth schedule of Kenya's constitution 2010, the transitional Authority was tasked to facilitate the phased transfer of functions from national government to county governments, health as a devolved function is still influenced heavily by the national government especially with reference to resource allocation which is key to the delivery of quality services to the people. There have been challenges in the development of framework for the comprehensive and effective transfer of resources to county governments to facilitate development of budgets in devolved governments hindering service provisions and more so in the health sector. This confirms the postulations of Bossert (1998), principal agent theory that the central government is a principal actor and it uses various forms to control decentralized governments and here it manifest itself it form of resource allocation to county governments.

The Parliament of Kenya, which consists of the National Assembly and the senate, is established under Art.93 of the Constitution. Among its functions is the appropriation of funds for expenditure by the national government and other national State organs and the exercise of oversight, over national revenue and its expenditure; determines the allocation of national revenue between the levels of government, as provided in Part 4 of Chapter Twelve; Deliberate on and resolves issues of concern to the people. The main role of Senators is to represent the counties, while also serving to protect the interests of the counties and their governments. Other roles include: Participating in the law-making function of Parliament by considering, debating and approving Bills concerning counties, as provided in Art.109 to 113, determining the allocation of national revenue among

counties, as provided in Art. 217, and exercises oversight over national revenue allocated to the county governments. But the role of parliament will be rendered useless if the national government continues to micro manage resource allocation to county governments as even the newly created structures will not be able to function well.

Figure 6.1 Structure of Busia County Health System



Source: (Collected data 2018)

The respondents' reactions were shown in Table 6.1 below.

Table 6.1 Effect of Organization Structure on Quality service delivery in health care

Statements	SA		A		N		D		SD		Mean	StD
	C	%	C	%	C	%	C	%	C	%		
The County has an Organization's structure that supports healthcare quality service delivery	6	5.7	23	21.7	5	4.7	66	62.3	6	5.7	2.70	1.05
Organization's structure is not aligned according to the central government	7	6.6	25	23.6	5	4.7	64	60.4	5	4.7	2.67	.830
Our organization's structure focuses on Centrality in reporting	6	5.7	56	52.8	9	8.5	27	25.5	8	7.5	2.87	.942
There has been change of organizational structure to support healthcare quality service delivery	11	10.4	58	54.7	7	6.6	23	21.7	7	6.6	2.69	.742
Our County constantly embraces change	7	6.6	52	49.1	8	7.5	27	25.5	12	11.3	3.16	.808
Our organization's structure uses a Flat line policy and structure	12	11.3	65	61.3	3	2.8	17	16.0	9	8.5	3.12	.702
We have a rigid bureaucracy	9	8.5	65	61.3	5	4.7	21	19.8	6	5.7	2.55	1.89
We have a Straight line structure without too many levels of hierarchy	9	8.5	66	62.3	5	4.7	19	17.9	7	6.6	2.73	.929
Our organization's structure had not been effective in enhancing healthcare quality service delivery	10	9.4	64	60.4	5	4.7	18	17.0	9	8.5	2.12	1.38

Source: Collected Data, 2018

6.2 Organization structure that supports healthcare quality service delivery

From Table 6.1, it is clear that when the respondents were asked if the County had an Organization's structure that supported healthcare quality service delivery, majority at 68% disagreed with the assertion. One of the respondents stated as follows;

> *"County government is a new introduction in the Kenyan Constitution and health has for long been a central government activity just like all other government institutions. Counties are struggling to implement projects fully because they depend on the national government. The structures in place are not fully effective and the conflict of interest has led to frequent medical practitioners and nurses calling for strikes".*

The above findings confirms the findings of Gilson et…, al (1994), which studied health systems in several African countries and highlighted an inadequate planning process, lack of management capacity and understanding within the district health management teams as some of the main factors affecting the service delivery capacity of district health systems. These weaknesses were also reported by a study on the Tanzania systems by Benettet al…, (199). This study confirms that indeed devolved health structures inefficient in service delivery and the same assertion is corroborated by a study made in Gambia, where Gambia embarked on a decentralization policy in the health sector in 1990. Regional management teams were established to oversee delivery of health care services at the regions. However, very little was achieved in terms of improvement in delivery of health care services until a donor-funded management strengthening project was established in 1991 (Conn et al..., 1996). Through this project, both decentralized management and accountability were promoted and management capacity was developed using a 'learning by doing' approach.

Another group of 27.4% agreed because they believe that nothing can be perfect because of change. The structures in place are good and the problem may only arise from the officers in charge who may not be willing or are reluctant in putting quality as the ultimate goal. There were few respondents at 4.7% who were undecided. This implied that there was a problem with the way the organization was structured and this affected healthcare quality service delivery. This could further lead to the assertion by Chandler (2002) on strategy and structure, that there is a need for building an internal organization structure that is responsive to the needs of the project. This study observed that the simplest organization structure that will do the job is considered the best one. From the findings, results showed indeed organizational structure is a major factor influencing implementation of quality health service delivery. This finding supports observations by other scholars. Porter et al.., (1964) suggested that decentralization of authority is one way of reducing problems associated with tall hierarchies and bureaucratic costs. Khayota (2014) opines that organizational structures influence implementation of strategic plans through task allocation, decentralization of authority, span of control, employee coordination and integration and structural flexibility. Decentralization of authority and flexibility in decision making have great bearing on implementation of strategic plans as agreed by the majority of the respondents.

Quain (2019) proposes that a good organizational structure creates a system by which a leader can delegate decisions, identify roles and responsibilities and define the chain-of-command. In other words, an organizational structure is a framework that helps employees achieve their goals and do their jobs in the most efficient and productive way.

Phillips et al…, (2000) says a good organizational structure makes employee training easier to administer. When organizational structure regulates the flow of information, then changes in information are easier to monitor and update in the organization-wide training program. When a defined hierarchy is in place, an organization is better equipped to make important decisions and adjust practices to meet the demands of competition.

Hao et al…, (2012) suggests that an organizational structure is a valuable tool in achieving coordination, as it specifies reporting relationships (who reports to whom), delineates formal communication channels, and describes how separate actions of individuals are linked together. Organizations can function within a number of different structures, each possessing distinct advantages and disadvantages. Although any structure that is not properly managed will be plagued with issues, some organizational models are better equipped for particular environments and tasks.

Burton et al…, (2006) proposes that an organization structure provides a point of reference and improves the flow and direction of communications. It allows people to see how they fit in the big picture, increases efficiency, and maintains a balance in the practice. Medical practices have both structure and process. The structure refers to the formal organization and the plans, schedules, and procedures that hold it together. Structure is the instrument by which people formally organize themselves to carry out a task. Process represents what actually goes on—what is done, how it is done, and the way individuals or groups behave and carry out their perceptions of the assigned tasks. It is also a pity since structure dictates the relationship of roles in an organization, and therefore, how people function. The findings of this study is further corroborated by Thomas et…, (2014) study who conducted an in-depth empirical study in 38 municipalities across South Africa, the study indicated

that the main objectives of setting up decentralized units largely failed to achieve the desired objectives. Failure was associated with inadequate institutional capacity for municipal government to implement the devolved functions. Cameron, 2013, highlighted the role of politics in a decentralized system in South Africa. The housing project was shared between national, provincial, and municipal governments; the national governments influenced the implementation of this initiative a result confirming the relevance of principal agent theory to the study findings.

6.3 Alignment of the County Health Organizations Structure to the Central Government

The Constitution of Kenya, 2010 created a devolved system of government where every county has both Legislature and the Executive systems in all the 47 Political and Administrative Counties as provided for under Article 6 and specified in the First Schedule. The main goal of creating devolved systems of governments was to decentralize administrative power, resources, and representation down to the county level. Devolution treated the inefficiency and laxity that had been experienced in the health sector. It was proposed that allocation of resources to the grassroots would enhance service delivery and hence improve the quality of life (Hope et al…, 2014).

Before the enactment of the 2010 constitution, health services were under the Ministry of Health, the hospital administration and heads of department had powers and resources to control administrative operations such as budget planning, recruitment, resource mobilization, developing, implementing and monitoring procedures, policies and performance standards for medical, nursing, technical and administrative staff. The Fourth Schedule of the Kenyan 2010 constitution provided specific directives on which services

the county or national governments are to provide. Essential health service delivery is assigned to county governments, while the national government retains health policy, technical assistance to counties and management of the national referral hospitals. Each county has a governor who appoints the chief executives of various departments including health. Every county has its own criteria of financing, monitoring and supporting service delivery. Management at the county level comprises of; County Executive Officer (CEC), Chief Officer and County Management Team (CMT). The CMT comprises of; director of health services, administrative officer, heads of units and medical superintendent of county hospitals. At the hospital level management is split in to two; Hospital Management Board (HMB) and Hospital Management Team (HMT).

When the respondents were asked if the organization's structure was aligned according to the central government, 65.1% disagreed. From this finding it was realized that the County government structure is different from the national government one because the national is headed by a Cabinet Secretary answerable to the president and at the county is Chief Executive Committee member. The counties have developed short term plans to meet health clients' needs. The lack of shared mission and vision at the counties departments of health with different policy objectives and strategic priorities make is the cause of difference in the structural alignments.

There were 30.2% who agreed and 4.7% were undecided. The processes at the national level have been followed at the county level though they may not be exactly the same. The guidelines for review and budgeting existed at the centralized government but still applied at the counties. This implies that consequent structure and all its attendant problems were

basically borrowed from the national government in as much as each county had the power to change it to suit their performance needs.

This study is supported by Richards (2006) cognizant of this finding which noted that as organizations grow, the size and number of their functions and divisions increased. To economize on bureaucratic costs and effectively coordinate the activities of people, functions, and divisions, managers must develop a clear and unambiguous hierarchy of authority or chain of command that defines each manager's relative authority from the CEO down through the middle managers and first-line managers to the non-managerial employees who actually make goods or provide services.

6.4 County Governments structure on Monitoring & Evaluation of Healthcare Service Delivery

Monitoring and evaluation influences the decisions made when discontinuing and improving an intervention or policy. Many changes in the government of Kenya have introduced more policies that match with the new structures in the counties. Therefore, there is the need for developing and implementing models of monitoring and evaluating the delivery of health services under the devolved health care system. This study examined the way monitoring and evaluation process can influence the organizational environment of the devolved health sector in Kenya. A Study conducted by Roy et al.., (1994) on the impact of devolution on the healthcare system in Pakistan established that devolution had a progressive impact on monitoring and supervision of the delivery of healthcare services and led to more financial autonomy allowing the relevant authorities to prioritize according to the needs. However, the study also identified different challenges facing the delivery of care following devolution which includes poor governance, inadequate human capacity,

late releases of funds, poor governance and lack of healthcare facilities such as laboratories and wards, which corroborates the views of the majority of respondents at 58.5% agreed that the county government structure is monitoring and evaluating and reporting on employees performance.

This implies that the county government health structure focuses on ensuring proper coordination and communication. Among the respondents, 33% disagreed and 8.5% were neutral. Communication strategy exists in all organizations because it is the basis for proper policy framework and stakeholder coordination. This gives an indication that the structure was a simple one. Pearce & Robinson (1991) identified five structural types. The five types include simple structure that is controlled by individuals, typical of small size operations, functional structures with a Chief Executive Officer (CEO) with prime activity centered in areas like Finance, Marketing, Production and others below him as this finding seems to suggest.

According to Neil (2019), a centralized organizational structure is a setup in which most power and critical decision-making responsibilities are concentrated with a few key leaders. Vision is a key trait of effective leadership and having a more centralized structure keeps all levels of an organization focused on one vision or purpose. A governor can establish and communicate his vision or strategy to all employees and keep all levels moving in the same direction. This prevents inconsistency in vision and helps the county deliver a common message to the local communities. Nelson et al…, (2005) says with fewer people involved in discussing and deciding on strategy and action, centralized organizations typically react more quickly to a dynamic situation. Leaders can gather information and efficiently discuss pros and cons of decisions in a small group. This makes

the communication and decision making process much more efficient than in decentralized structures in which many local managers must participate in the process. Once decisions are made, top managers send out directives to lower levels for implementation.

Boufford (1999) suggests that when only one person or small groups at the top make important decisions, organizations experience less conflict and dissent among lower to mid-level employees. If many employees and levels in the organization get involved in decisions, more potential exists for disputes and difference in implementation. With top managers taking responsibility of making and implementing critical decisions, they insulate other managers and leaders from the burden of making risky or unfavorable decisions. This is especially important to lower manager- employee relationships.

Campbell et al.., (1993) proposed that when centralized leaders are in charge of all major decisions, they retain more control over the organization operations and development of its culture. Additionally, little question exists over who is accountable for the results of those decisions. If the organization gets a bad price in a supplier negotiation, top managers know to turn to procurement manager to get a sense of what went wrong. This accountability causes top managers to drive each other to peak performance.

Bartlemetet al…, (1981) noted that in organizations with strong centralized leadership, employees typically have well-defined job descriptions and roles. When employees are aware of their duties, as well as the duties and responsibilities of their coworkers, they are often more likely to be productive and feel more confident in making decisions within their sphere of responsibility. Morale may also improve, as workers may be less likely to resent each other for either overstepping boundaries, on the other end of the spectrum, not working hard enough. When workers have well-defined responsibilities, it can be easier for

management and human resources to determine whether there is a need for creating new roles or hiring more employees. This can help keep costs down by avoiding redundant hires while also making it easier to recruit qualified workers for necessary positions.

According to Nelson (2005), centralization is the degree to which decision-making authority is concentrated at higher levels in an organization. In centralized organizations, many important decisions are made at higher levels of the hierarchy, whereas in decentralized organizations, decisions are made and problems are solved at lower levels by employees who are closer to the problem in question.

6.5 Change of Healthcare Organizational Structure from National to County Government

On whether there had been change of organizational structure to support healthcare quality service delivery, 65.1% agreed, 28.3% disagreed and 6.6% were undecided. This gave a positive implication that the County had noticed problems with the structure as it stood and were considering improvising to ensure that healthcare quality service delivery is realized. This finding was observed and agreed to by literature from Hill and Jones (2010) supplementing that when managers know exactly what their authority and responsibilities are, information distortion problems that promote managerial inefficiencies are kept to a minimum, and handoffs or transfers can be negotiated and monitored to economize on bureaucratic costs together with restructuring of the organization to meet strategic needs.

Among those who agreed, one of the respondents explained as follows;

> "The structure of coordination changed at the county level to fit the command structure where the head of county is the Governor from the national one of the presidency. The county health departments had been there but are changed to fit several county management teams and functionalities".

Among those who disagreed, there was a respondent, who stated that;

> "The structures that existed before in the Municipal and county councils are today classified under the county government and where they have been answerable to an authority is today replaced by the county government officers. The structure has not changed but a little of alignments and re-alignments".

Mays et al.., (2000) defined organizational change as the movement of an organization from one state of affairs to another. A change in the environment often requires change within the organization operating within that environment. Change in almost any aspect of an organization's operation can be met with resistance, and different cultures can have different reactions to both the change and the means to promote the change. To better facilitate necessary changes, several steps can be taken that have been proved to lower anxiety of employees and ease the transformation process. Often, the simple act of including employees in the change process can drastically reduce opposition to new methods. In some organizations, this level of inclusion is not possible, and instead organizations can recruit a small number of opinion leaders to promote the benefits of coming change.

Misraet al..., (1994) says organization change may involve a change in an organization's structure, strategy, policies, procedures, technology, or culture. Organizational change can be radical and swiftly alter the way an organization operates, or it may be incremental and slow. In any case, regardless of the type, change involves letting go of the old ways in which work is done and adjusting to new ways. Therefore, fundamentally, it is a process that involves effective people management.

Draper et al…, (2002) suggests that managers carrying out any of the planning, organizing, leading or controlling functions often find themselves faced with the need to manage organizational change effectively. Often, the planning process reveals the need for a new or improved strategy, which is then reflected in changes to tactical and operational plans.

Creating a new organizational design (the organizing function) or altering the existing design entails changes that may affect from a single employee up to the entire organization, depending on the scope of the changes. Effective decision making, a leadership task, takes into account the change management implications of decisions, planning for the need to manage the implementation decisions. Finally, any updates to controlling systems and processes will potentially involve changes to employees' assigned tasks and performance assessments, which will require astute change management skills to implement. In short, change management is an important leadership skill that spans the entire range of planning, organizing, leading and controlling functions.

Baskerville et al…, (2013) said an outdated organization structure could result in unnecessary ambiguity and confusion and often a lack of accountability. Poor organizational structure could results in a bewildering morass of contradictions: confusion within roles, a lack of co-ordination among functions, failure to share ideas, and slow decision-making brings managers unnecessary complexity, stress, and conflict. Often those at the top of an organization are oblivious to these problems or, worse, pass them off as or challenge to overcome or opportunities to develop.

When the respondents were asked if the County constantly embraced change, 55.7% agreed, 36.8% disagreed and 7.5% were undecided. This gave an indication that the concept of change was a factor that was considered when it arose. Communication of change and its embrace was central to the strategic implementation success of most or all organizations. And when change was occurring in an organization, communication was even more essential to implement that change effectively. However, one problem for many modern organizations was that change was not always communicated effectively.

Embracing change has a number of benefits, which include; enhanced respect and reputation, strengthens the leaderships' image, improved growth opportunities, increased job satisfaction, and increased job security. Refusing to embrace change has a number of consequences, which include reduced job satisfaction, lost opportunities for advancement, and loss of employment (Burke, 2008)..

6.6 Communication of structural changes

On whether structural changes were communicated to all employees, 67.0% disagreed, 26.4% agreed and 6.6% were undecided. This implied that communication of change was a problem. Communication of change and its embrace was central to the strategic implementation success of most or all organizations. And when change was occurring in an organization, communication was even more essential to implement that change effectively. However, one problem for many modern organizations was that change was not always communicated effectively (Burke, 2008).

Bartlemet et al…, (1981) suggests that when organizational strategy changes, structures, roles, and functions should be realigned with the new objectives. This doesn't always happen, with the result that responsibilities can be overlooked, staffing can be inappropriate, and people and even functions can work against each other. More often than not, though, the hierarchy remains embedded in the "new" structure, which can cut across its effectiveness and leave people confused. Worse, organizations rarely show people how to operate in a new structure, which can also undermine effectiveness.

Jones (1996) concludes that human resources professionals will also need to have an understanding not only of the HR area, but of all areas of an organization, including

strategy, finance, operations, etc. This need will have an impact on the educational preparation as well as the possible need to have work experience in these other functional areas.

Martinez and Closter (1998) observed that one strategy to help lessen the negative impacts of changes in healthcare financing undertaken by some public health departments has been the development of formal relationships, for example, negotiating and implementing memoranda of agreement, with local managed care organizations that provide medical aid and, in some cases, safety-net services. Such arrangements have made possible some level of integration of healthcare and public health services, enhanced information exchange and continuity of care, and allowed public health departments to be reimbursed for the provision of some of the services that are covered by the benefits packages of managed care plans.

6.7 Efficiency of Organizational Structure

Finally, when asked if generally, organization's structure had been effective in enhancing healthcare quality service delivery, 69.8% agreed, 25.5% disagreed and 4.7% were undecided. This implies that there was no effective implementation occasioned by poor organizational structure. Using the three basic dimensions of; key part of the organization, prime coordinating mechanism, and type of decentralization, Martinez and Closter (1998) suggested that the strategy an organization adopted and the extent to which it practiced that strategy resulted in five structural configurations: simple structure, machine bureaucracy, professional bureaucracy, divisional form, and adhocracy and he advocated for an inclusive system that has decisions made from experts without hierarchical bottlenecks.

6.8. Summary of the Chapter

This chapter discussed the findings on the influence of organizational structure on quality healthcare delivery in Busia County. It also discussed the effects of organizational alignment to central government, change of health structure and efficiency of the health organizational structure in delivering health services in Busia County.

CHAPTER SEVEN

EFFECTS OF HEALTHCARE WORKERS COMPETENCE ON QUALITY SERVICE DELIVERY

7.1 Introduction

This chapter deals with the effect of healthcare workforce competence on quality healthcare service delivery in Busia County. The chapter is divided into sections based on the interviewee's opinion and the key respondents who were interviewed. It begins by looking at health work force competence and quality service delivery. This is followed by healthcare workforce competence, approaches to improve healthcare work force and quality of work done by healthcare works. It concludes by discussing healthcare employees' efficiency. The respondents expressed their opinion and views on the influence of health workforce competence on devolved healthcare quality service delivery in Busia County.

7.2 Healthcare Workforce Competence and Quality Service Delivery

The fourth objective sought to establish how health workforce competence influenced the realization of efficiency in healthcare quality service delivery in Busia County. Competency of workforce is also informed by the principal agency theory where its main proponent Bossert (2008), advocates for increased flexibility in decision making processes concerning human resources. He particularly emphasizes that managers should be given room to hire and fire so as to increase efficiency and quality of service delivery. However, according to him there is need for a cautious approach as this power can be abused if not managed well. The respondents' reactions were shown in Table 7.1.

Table 7.1 Health Workforce Competence and Quality Service Delivery

Statements	SA		A		N		D		SD		Mean	StD
	C	%	C	%	C	%	C	%	C	%		
Healthcare workforce competence is high for better service delivery	6	5.7	23	21.7	5	4.7	66	62.3	6	5.7	2.70	1.05
Workable approaches to improve healthcare workforce competence is available for better service delivery	7	6.6	25	23.6	5	4.7	64	60.4	5	4.7	2.67	.830
The quality of work done out of the Health workforce is often of top quality	11	10.4	58	54.7	7	6.6	23	21.7	7	6.6	2.69	.742
The status of the health workforce is so far competent	7	6.6	52	49.1	8	7.5	27	25.5	12	11.3	3.16	.808

Source: Collected Data, (2018)

7.3 Healthcare workforce competence

The findings indicate as shown in table 7.1 that majority at 68.0% disagreed with the assertion that healthcare workforce competence was high for better service delivery. Competencies have been used as a framework to guide employees on organizations matters that drive towards its success. Majority disagreed because they do not see innovative employees and that organizations do not develop and nature talents. There were those 26.4% of the respondents who agreed and 4.7% were undecided. One of the key

respondents was categorical why he thought healthcare workforce should be high for better service delivery. The respondent stated that;

> *"When healthcare workforce competence is high, employees are likely to offer quality services compared to less competent ones. Competence mostly leads to quick and timely provision of a service".*

This implies that there was a problem with Healthcare workforce competence. Noble (2000) in supporting this result had noted that a myriad of factors can potentially affect the process by which workforce competence are turned into organizational action. Unlike strategy formulation, workforce implementation is often seen as something of a craft, rather than a science and its research history has previously been described as fragmented and eclectic. It was thus not surprising that after a comprehensive strategy or a single strategic decision had been formulated, significant difficulties usually arose during the subsequent implementation process.

Campbell et al.., (1993) highlights that, "proper management of human resources is critical in providing a high quality of health care". Effective human resources management strategies are greatly needed to achieve better outcomes from and access to healthcare in the counties. Human resources, when pertaining to health care, can be defined as the different kinds of clinical and non-clinical staff responsible for public and individual health intervention. As arguably the most important of the health system inputs, the performance and the benefits the system can deliver depend largely upon the knowledge, skills and motivation of those individuals responsible for delivering health services.

Fleishman and Bartlett (1969) assert that competence encompasses knowledge, skills, abilities, and traits. It is gained in the healthcare professions through pre-service education, in-service training, and work experience. Competence is a major determinant of provider

performance as represented by conformance with various clinical, non-clinical, and interpersonal standards. Measuring competence is essential for determining the ability and readiness of health workers to provide quality services. Although competence is a precursor to doing the job right, measuring performance periodically is also crucial to determine whether providers are using their competence on the job. A provider can have the knowledge and skill, but use it poorly because of individual factors (abilities, traits, goals, values, inertia) or external factors (unavailability of drugs, equipment, organizational support).

Boyatzism, (1982) says that competence refers to a person's underlying characteristics that are causally related to job performance. Competence is defined in the context of particular knowledge, traits, skills, and abilities. Knowledge involves understanding facts and procedures. Traits are personality characteristics (for example, self-control, and self-confidence) that pre-dispose a person to behave or respond in a certain way. Landy, (1985) defines a skill as the capacity to perform specific actions: a person's skill is a function of both knowledge and the particular strategies used to apply knowledge. Abilities are the attributes that a person has inherited or acquired through previous experience and brings to a new task: they are more fundamental and stable than knowledge and skills. Lane and Ross (1998) define competence as the ability to perform a specific task in a manner that yields desirable outcomes. This definition implies the ability to apply knowledge, skills, and abilities successfully to new situations as well as to familiar tasks for which prescribed standards exist.

According to Benner (1984), health workers acquire competence over time. Typically, pre-service education or an initial training opportunity creates a novice who, after additional

training and hands-on experience, reaches a level that can be certified as competent. Although competence is considered to be a major milestone in professional development, it is not the final point. That comes with proficiency, and the ultimate status of expert comes after many years of experience and professional growth.

Southgate and Dauphinee, (1998) assert that Competence is one of many determinants of performance. The relationship between competence (can do) and performance (does do) is complex: the first does not always predict the second. Obviously, less competent providers are less likely to provide quality services, and healthcare providers must have the competencies necessary to perform their jobs according to standards in order to provide quality services.

While, (1994) says attempts are sometimes made to measure competence in terms of performance. However, competence should not be inferred from performance. While competence is defined in terms of someone's capacity to perform, performance is the resulting behavior. "Performance is something that people actually does and can be observed. By definition, it includes only those actions or behaviors that are relevant to the organization's goals and that can be scaled (measured) in terms of each person's proficiency (that is, level of contribution). Performance is what the organization hires one to do, and do well".

Spencer et al…, (1994) noted that extensive research showed that the more the person's competencies match the requirements of a job, the more effective the person will be performing. However, competency does not always lead to effective performance. There is a difference between what an individual should be able to do at an expected level of

achievement and what he or she actually does in a real-life setting. A number of other factors including personal motivation, adequate support of the hospital authorities, colleagues, and even non-professional health workers can affect worker performance.

According to Krall (1998), motivation is reflected in the completeness, the intensity, and the persistence of effort. For example, a healthcare worker may be competent to perform a medical procedure, but may not be willing to expend the effort to perform all the required behaviors.

Locke and Latham (1990), ascertains that motivation is strengthened and providers work with more completeness, intensity, or persistence when: they are committed to a clear and challenging goal, their job offers an opportunity to demonstrate mastery rather than an occasion to be evaluated, they believe that a particular procedure or standard will be effective and they have high expectations for success.

Moos (1981), assert that individual traits can also determine motivation. For example, people with a disposition for accomplishing challenging objectives work harder .Factors external to the individual and related to organizational and social conditions also influence provider behavior and performance. There is evidence that higher performance is associated with sufficient resources to perform the job, clear role expectations and standards of performance feedback on performance, and rewards that are contingent on good performance and the nature of the reward. In general, the expectations of the organization, profession, and community may influence the behavior and performance of providers for better or worse. For example, lack of supervision may result in some health workers' cutting corners inappropriately. Of course, unavailability of basic resources (such as equipment, supplies, and medicines) can result in poor performance in spite of high

competence and motivation. Schuler et al…, (1985) says that provider performance varies and is partly determined by the social standing, awareness, and expectations of the client. Poorer, less educated, and less demanding clients often receive less attention.

Kanungo and Jaeger, (1990) suggests that peer pressure plays a role, and some providers fail to comply with standards even if they have the requisite knowledge and skills. The socio-cultural environment in which people were raised, live, and work affects job performance. "Any meaningful analysis of work motivation in developing societies has to be juxtaposed with an analysis of the physical and socio-cultural environment as well as the stable attributes of the individual who is a product of such an environment."

Misra and Kanungo, (1994) suggests that organizations need to adopt management practices that are consistent with local conditions. Mendonca and Kanungo, (1994) propose that managers set goals within the employee's current competencies and increase those goals as the employee experiences success and feels more capable of achieving more difficult goals.

7.4 Workable Approaches to Improve Healthcare Workforce Competence

There are many good reasons for measuring competence. Ministries of health, professional organizations, and healthcare organizations must ensure that appropriate expectations for competence are set and that their staff performs to standard. Healthcare organizations must meet certain criteria to provide services and through certification, licensure, and accreditation are able to exert control on health providers and, as a result, to influence the quality of healthcare. The respondents were asked if workable approaches to improve healthcare workforce competence were available for better service delivery. In healthcare competence can be acquired pre-service education and in-service training CHR (1999).

According to Jansen et al...,(1995)workable approaches used to measure competency includes assessment methods, written and computerized tests, review of medical records and job simulations.

From the findings, 65.1% disagreed with the argument that there are no workable approaches and the organization or the health department should rather develop its policies that if carefully implemented may provide solution to the problem or increased service delivery. However, 30.2% agreed on the idea because they hold the view that well formulated policies exist but the implementation phase is the problem. One key respondent argued as follows;

> *"There are good policies at the county governments in relation to provision of better healthcare services. The county government officers in the health department should develop proper guidelines towards implementation. If the policies are well implemented, there will be better quality healthcare services".*

There were however 4.7% undecided respondents. This implies that consequent to lack of competent employees, a strategic conducive environment to create effective work was not present. In supporting this result, Per et al…, (2008) had noted that lack of proper implementation excludes aspects of who would be responsible for the implementation, the most suitable organizational structure to support the strategy and the relevant systems needed by the organization to track and monitor the progress.

Vujicic et al…, (2004) proposed that the balance between the human and physical resources, it is also essential to maintain an appropriate mix between the different types of health promoters and caregivers to ensure the system's success. Due to their obvious and important differences, it is imperative that human capital is handled and managed very differently from physical capital. The relationship between human resources and healthcare

is very complex, and it merits further examination and study. Workforce training is another important issue. It is essential that human resources personnel consider the composition of the health workforce in terms of both skill categories and training levels. New options for the education and in-service training of healthcare workers are required to ensure that the workforce is aware of and prepared to meet a particular county's present and future needs. One of the respondents observed that...

> *"Competency measurements that predict job performance may increase the chances that a remedial action will be identified and will increase job performance of trainees who score low on end-of-training competency test".*

Grupta et al…, (2003) suggests that a properly trained and competent workforce is essential to any successful healthcare system, the opinion which conquers with the views of the respondents in this study. In addition to salary incentives, counties could use other strategies such as housing, infrastructure and opportunities for job rotation to recruit and retain health professionals, since many health workers in the countries feel they are underpaid, poorly motivated and very dissatisfied.

Zurn et al…, (2004) observed that the migration of health workers is an important human resources issue that must be carefully measured and monitored. Various human resources initiatives have been used in an attempt to increase efficiency. Outsourcing of services has been used to convert fixed labor expenditures into variable costs as a means of improving efficiency. Contracting-out, performance contracts and internal contracting are also examples of measures employed. Many human resources initiatives for health sector reform also include attempts to increase equity or fairness. Strategies aimed at promoting equity in relation to needs require more systematic planning of health services. Some of

these strategies include the introduction of financial protection mechanisms, the targeting of specific needs and groups, and re-deployment services.

According a respondent periodic appraisal by supervisors or peers and self-assessments can also be used to infer competence in healthcare institutions where observations of provider-patient interactions, record reviews, patient interviews and self-appraisals are used .Kirby, (2002) says that better use of the spectrum of healthcare providers and better coordination of patient services through interdisciplinary teamwork have been recommended as part of health sector reform. Since healthcare is ultimately delivered by people, effective human resources management will play a vital role in the success of health sector reform. Starfield et al…, (2002) says that one of the initiatives made by human resources professionals in an attempt to improve the overall standard of care in the hospital was to examine and shape the organization's corporate culture. Steps were taken to define the values, behaviors and competences that characterized the current culture, and analyze these against the desired culture. The goal of human resource professionals is to empower employees to be more creative and innovative. To achieve this, a new model of care was designed that emphasized a decentralized nursing staff and a team-based approach to patient care. Nursing stations were redesigned to make them more accessible and approachable. Fried, (2008) says that human resources management also played an important role in investing in employee development. This was achieved by assisting employees to prepare and market themselves for internal positions and if desired, helping them pursue employment opportunities outside the organization. This case makes obvious the important roles that human resources management can play in orchestrating organizational change.

Flynn et al…, (2015) exerts that the importance of human resources management to the healthcare system is that it enables management to recognize some of these challenges facing the healthcare sector, which included intense price competition and payment reform in health care, reduced state and federal funding for education and research, and changing workforce and population demographics. The organizational administrators recognized that a cultural reformation was needed to meet these new challenges. A repositioning process was enacted, resulting in a human resources strategy that supported the organization's continued success. This strategy consisted of five major objectives, each with a vision statement and series of action steps. The objectives included: staffing, performance management; development and learning; valuing people; and organizational effectiveness.

Fottler (2011) suggested that human resources initiatives aimed at improving organizational culture had a significant and positive effect on the efficiency and effectiveness of the hospitals and healthcare systems. Ultimately all Healthcare is delivered by people, so healthcare management can really be considered people management; this is where human resources and professionals must make a positive contribution.

Fried et al…, (2015) noted that human resource professionals understand the importance of developing a culture that can enable an organization to meet its challenges. They understand how communities of practice can form around common goals and interests, and the importance of aligning these to the goals and interests of the organization. Since all Healthcare is ultimately delivered by and to the people, a strong understanding of the human resources management issues is required to ensure the success of any healthcare program. Further human resources initiatives are required in many healthcare systems, and more extensive research must be conducted to bring about new human resources policies

and practices that will benefit individuals around the world. Certain shortages of healthcare professionals in disciplines such as pharmacy and dentistry have a significant adverse effect on the quality of health care.

One of the respondents held the opinion that the county government lacks the man power and resources to carry out overall assessment a fact which was corroborated by Bates et al…, (1998) suggestion that the development of enhanced information technology and its use in hospitals, individual provider practices, and other segments of the healthcare delivery system are essential for improving the quality of care. Better information technology can also support patients and family caregivers in crucial health decisions, strengthen both personal and population-based prevention efforts, and enhance participation in and coordination with public health activities.

Dranove et al..., (2002) proposes that from the provider perspective, better information systems and more extensive use of information technology could dramatically improve care by offering ready access to complete and accurate patient data and to a variety of information resources and tools clinical guidelines, decision-support systems, digital prescription-writing programs, and public health data and alerts, for example that can enhance the quality of clinical decision making. Computer-based systems for the entry of physician orders have been found to have sizable benefits in enhancing patient safety.

Another respondent who agreed on the existence of competency programme of assessing the healthcare workers believed that, a single observation of performance does not provide a reliable estimate of the provider's competence an opinion which Safian (2009) agrees with and suggests that healthcare organizations need to assess individual and organizational

performance periodically to assess the efficacy of their services. The results help healthcare organizations determine whether they need to design training and/or continuing education interventions for improving provider performance. Comparing assessments of competence and job performance may indicate the extent to which the organization provides the support needed for quality care. High competency and low performance may signal that an organization is not providing the needed resources, has not clarified standards of care, or is not rewarding effective performance or correcting poor performance.

7.5 Quality of work done by the Health workforce

On whether the quality of work done out of the Health workforce was often of top quality, 65.1% agreed, 28.3% disagreed and 6.6% were undecided. This implied that there was good quality work done at the counties despite the challenges faced by the healthcare system.

The findings concur with the research conducted by Steiner (2004) who stated that both the number and cost of healthcare consumables (drugs, prostheses and disposable equipment) are rising astronomically, which in turn can drastically increase the costs of health care. In publicly-funded systems, expenditures in this area can affect the ability to hire and sustain effective practitioners. In both government-funded and employer-paid systems, HRM practices must be developed in order to find the appropriate balance of workforce supply and the ability of those practitioners to practice effectively and efficiently. A practitioner without adequate tools is as inefficient as having the tools without the practitioner.

Hrebiniak et al…, (2006) recognizes human resources in health sector reform also seek to improve the quality of services and patients' satisfaction. Healthcare quality is generally

defined in two ways: technical quality and socio-cultural quality. Technical quality refers to the impact that the health services available can have on the health conditions of a population. Socio-cultural quality measures the degree of acceptability of services and the ability to satisfy patients' expectations.

7.6 Efficiency of Implementation of Healthcare by the Healthcare Workforce

Finally, the respondents were asked if the implementation of Health workforce at the County was not so far competent, 55.7% agreed, 36.8% disagreed and 7.5% were undecided. This gave an indication of lack of effective workforce competence, had led to a feeling that it was not timely and sustainable attributing it to a demotivated workforce.

It is within the purview of this study that health staff is often recruited without conducting an in-depth analysis of competency requirements and there is a growing belief that it is simply impossible to improve a person’s performance until specific competencies required for satisfactory or superior performance are identified. It is only after these competencies are identified that staff can be selected. Some new recruits may require skill or knowledge enhancement to be able to perform optimally. Research is needed to identify the impact of clearly defined competency requirements on staff performance not only in healthcare institutions but all public and private institutions. Human resource professionals face many obstacles in their attempt to deliver high-quality healthcare to citizens. Some of these constraints include budgets, lack of congruence between different stakeholders' values, absenteeism rates, high rates of turnover and low morale of health personnel .Furthermore, with healthcare becoming so technologically advanced, the healthcare system needs an increasing supply of highly specialized and skilled technicians .Clients need to see the

health worker most appropriate to deal with their problem. Spending public resources in educating professionals only to have significant numbers of them leave the country is not a financially desirable or sustainable situation for a country.

Rainer, (1999) said that human resources management plays a significant role in the distribution of healthcare workers. With those in more developed countries offering amenities otherwise unavailable, chances are that professionals will be more enticed to relocate, thus increasing shortages in all areas of health care. Due to an increase in globalization, resources are now being shared more than ever, though not always distributed equally. Health staff is often recruited without conducting an in-depth analysis of competency requirements. There is a growing believe that it is simply impossible to improve a person's performance until specific competencies required for satisfactory or superior performance are identified. It is only after these competencies are identified that staff can be selected. Some new recruits may require skill or knowledge enhancement to be able to perform optimally. Research is needed to identify the impact of clearly defined competency requirements on staff performance, if any.

7.8 Summary of the Chapter

This chapter discussed the findings on the competency on healthcare quality service delivery in Busia County. Workable approaches towards improvement of healthcare workforce and efficiency of implementation of healthcare by healthcare workforce was also discussed. The next chapter will discuss the summary of the findings, conclusion and recommendations.

CHAPTER EIGHT

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

8.1 Introduction

This chapter contains a summary of findings. The summary of the findings was done guided by the research objectives. The conclusions was drawn from the researchers understanding of the research problem and the recommendations made thereof. The research offers the suggestions for further research.

8.2 Summary of Findings

The first objective was on the influence of resource allocation on devolved healthcare quality service delivery in Busia County. In this study, all the respondents were learned. They had an understanding of variety of issues in relation to healthcare and in line with the term devolution. Majority at 48.1% had worked for the public service for more than 15 years which was good for the research because of their knowledge in centralized governance and now devolved units. Moreover, all the respondents had an idea of what devolution is. The expectations brought about by devolution are greater than perception and the perceived quality is less than satisfactory and a service quality gap materialized. Reliability is reliant to accuracy levels of the services rendered by the health institutions and is among the best characteristics of good service delivery.

It was found out that majority of the respondents at 61.3% were of the idea that the availability of the required resources in a health institution is to a great extend important in ensuring proper service delivery. It is clear that financial systems established by the organization to a little extent support quality service delivery in health care. The financial

systems and procedures are necessary components of Quality service delivery in healthcare. There are however some loopholes where the county funds are misappropriated and not utilized as intended as maintained by 17.9%. The county government of Busia has not embraced the use of IT as shown from the findings. The county has not enabled the public to access some of the health services online such as inquiries. Although it may have been used to some extent, the findings showed that there was no effective use of it to lower costs. This is an indication that resource allocation had a statistically significant effect on healthcare quality service delivery in the public service.

The second objective was on health leadership on devolved healthcare quality service delivery in Busia County. Majority of the respondents at 30.19% stated the Ministry of health is an actor which provides leadership in healthcare sector because of its long term role as a central government entity of health. Other actors from the findings include the private sector as an actor, public sector due to the massive public members requiring health services, individuals because of their initiatives that can assist in a wider perspective. There are 8.90% respondents who said that development partners are important actors in the healthcare sector because of their activities of ensuring resources are available.

Supervision is important for quality service delivery as stated by majority 70.8% respondents who believe that employees needed to be supervised closely, or they were not likely to do their work by the county health management team. In this line of thought, employees should be closely monitored if they have to meet strict deadlines and ensure health services are offered in time. However, decisions should not only be bottom-up but also top-bottom where the managers are the ones responsible for ensuring proper healthcare systems have policies and are implemented. The bottom-up approach may be the best to

improve the health services if the supervisor listens to the best decision practices from the employees. It is believed by majority 63.2% that leaders should let subordinates work problems out on their own although some think that allowing employees to work out problems on their own downs their morale and they fill neglected and not part of the institution and this role is better laced with hospital management committee. Instead, in complex situations, the institutions through the various line supervisors can create groups to work it out. The results further indicated that employees should be provided with direction regularly because they should be under supervision in carrying out their daily activities.

It may be stated that a good leader should not put pressure to the employees because they will not be working in freewill hence interfering with their morale and motivation. However, pressure assists employees to understand the situations and how they should be documenting risks and other concerns. Reward or punishment is good for employees because they can assist in creating motivation towards attainment of organizations goals. Care should be observed in using rewards or punishments because once it is taken as a rule, demotivation gets in which may lead to decline in quality service delivery.

Majority 72.6% of the respondents agreed that there should be supportive communication from the leaders because it creates an accommodative environment and makes the employees to feel linked to the management. Criticism is important for quality service delivery to be achieved. Employees are always insecure about their work and need direction hence the need to be well trained in order to avoid relying on the leaders. Furthermore, successes in an organization are a collective responsibility and leaders should not take achievements to be upon themselves to decide. It means that management

exercises power often to offer change needs in situations of emergencies and shortages in resources. Leaders should be motivational and should have the capability of identifying each employee's strengths and weaknesses and by so doing; they will focus on individual strengths and improve their weaknesses leading to improved quality service delivery especially in the health sector.

Good managers in an organization give direction especially on what needs to be done for proper and effective quality service delivery and the chief officer health should be responsible for it. Managers influence the environmental variables most likely to receive attention in the organization. This is an indication that health leadership had a statistically significant effect on healthcare quality service delivery in the public service. The county executive committee member for health and director of health services therefore should proper directions and enable conducive working environment for healthcare workers.

The study in its third objective was to examine the organizational structure influence on healthcare quality service delivery in Busia County. The findings of this study implies that lack of an effective organizational structure, leads to a number of challenges in providing high quality healthcare service delivery which include: poor identification and confusion within roles and responsibilities by the healthcare workers; lack of a definite chain-of-command; training and promotions of the workforce not well structured and administered, thus resulting to a demotivated workforce; poor focus and achievements of the departmental goals and objectives; poor flow of information; slow decision-making and delegation of decisions which bring managers unnecessary complexity, stress, and conflict; poor practices to meet the demands of competition; allocated resources would not be used prudently; individual and team work within the healthcare workforce would not be linked

and coordinated, a lack of co-ordination among functions and failure to share ideas. The lack of an effective organizational structure has led to the above reasons, which would affect the effective delivery of quality healthcare service delivery.

The organizational structure in Busia county healthcare sector is aligned according to the National government organizational structure and is led the county executive committee member for health, chief officer health and directors of health services. Collaboration between the national government and the county governments is therefore of great importance in guaranteeing the citizens of high quality healthcare services, as their roles overlap in implementation of the healthcare delivery system. The county needs to align its organizational structure to that of the central government structure, as this would promote closer collaboration and integration between the central governmental public health agencies and the county healthcare delivery system, which would enhance the capacities of both to improve population health and support the efforts of other public health system actors.

Busia County health sector has a strong centralized leadership; employees typically would have well-defined job descriptions and roles. The employees would be aware of their duties, as well as the duties and responsibilities of their coworkers, they would often more likely to be productive and feel more confident in making decisions within their sphere of responsibility. Morale may also improve, as workers may be less likely to represent each other for either overstepping boundaries, on the other end of the spectrum, not working hard enough. When workers have well-defined responsibilities, it can be easier for management and human resources to determine whether there is a need for creating new

roles or hiring more employees. This can help keep costs down by avoiding redundant hires while also making it easier to recruit qualified workers for necessary positions.

Busia County has constantly embraced change in its organizational structure. Embracing change has a number of benefits, which include: enhanced respect and reputation; strengthens the leaderships' image; improved growth opportunities; increased job satisfaction; and increased job security. Refusing to embrace change has a number of consequences, which include: reduced job satisfaction; lost opportunities for advancement; and loss of employment.

A straight line structure without too many levels of hierarchy existed in the county. It allows quick decisions and efficient coordination. It further promotes the unity of command. There is also accountability of delegated tasks. There is excellent discipline in a line organization due to unified control and undivided loyalties. The overall cost of running the organization is low due to the non-involvement of staff. Structural changes were not communicated to all employees in Busia county healthcare sector. When organizational strategy changes, structures, roles, and functions should be realigned with the new objectives.

One strategy to help lessen the negative impacts of changes in healthcare financing undertaken by the national government would be to develop formal relationships, for example, negotiating and implementing memoranda of agreement and enhance collaborations between the two levels of government. This is an indication that organizational structure had a statistically significant effect on healthcare quality service delivery in the public service.

The study's fourth objective was examining healthcare workforce competence influence on healthcare quality service delivery in Busia County. The study found out that proper management of human resources is critical in providing a high quality of healthcare. As arguably the most important of the health system inputs, the performance and the benefits the system can deliver depend largely upon the knowledge, skills and motivation of those individuals responsible for delivering health services. Competence is gained in the healthcare professions through pre-service education, in-service training, and work experience. Measuring competence is essential for determining the ability and readiness of health workers to provide quality services. Although competence is a precursor to doing the job right, measuring performance periodically is also crucial to determine whether providers are using their competence on the job.

Busia county health sector should attempt to measure competence in terms of performance. However, competence should not be inferred from performance. Performance is what the organization hires one to do, and do well. Obviously, less competent providers are less likely to provide quality services, and healthcare providers must have the competencies necessary to perform their jobs according to standards in order to provide quality services. A number of other factors including personal motivation, adequate support of the hospital authorities, colleagues, and even non-professional health workers can affect worker performance.

Busia county workforce needs to adopt management practices that are consistent with local conditions. The healthcare managers should set goals within the employee's current competencies and increase those goals as the employee would experience success and feel more capable of achieving more difficult goals. The socio-cultural environment in which

people were raised, live, and work affects job performance. For example, lack of supervision may result in some health workers' cutting corners inappropriately. Of course, unavailability of basic resources (such as equipment, supplies, and medicines) can result in poor performance in spite of high competence and motivation.

The respondents highlighted that Busia county healthcare sector, lacked workable approaches to improve the healthcare workforce competence. The balance between the human and physical resources, it is also essential to maintain an appropriate mix between the different types of health promoters and caregivers to ensure the system's success. The human capital should be handled and managed very differently from physical capital. The relationship between human resources and healthcare is very complex. It is essential that human resources managers consider the composition of the health workforce in terms of both skill categories and training levels. New options for the education and in-service training of healthcare workers are required to ensure that the workforce is aware of and prepared to meet a particular county's present and future needs.

The human resource professionals should try and improve the overall standard of care in Busia county healthcare sector by examining and shaping the organization's corporate culture. A repositioning process needs to be enacted, that could result in a human resources strategy that supports the county's continued success. This process strategy should focus on: staffing, performance management; development and learning; valuing people; and organizational effectiveness. Ultimately all Healthcare is delivered by people, so healthcare management can really be considered people management; this is where human resources professionals must make a positive contribution

The implementation of quality healthcare service delivery by the Busia county healthcare workforce was not effective since the workforce was not very competent. Human resource professionals face many obstacles in their attempt to deliver high-quality healthcare to citizens. Some of these constraints include budgets, lack of congruence between different stakeholders' values, absenteeism rates, high rates of turnover and low morale of health personnel, strikes and strike notices. Furthermore, with healthcare becoming so technologically advanced; the healthcare system needs an increasing supply of highly specialized and skilled technicians. Clients need to see the health worker most appropriate to deal with their problem. Spending public resources in educating professionals only to have significant numbers of them leave the country is not a financially desirable or sustainable situation for a country.

Busia County's human resources management should play a significant role in the distribution of healthcare workers. Due to an increase in globalization, resources are now being shared more than ever, though not always distributed equally. Health staff is often recruited without conducting an in-depth analysis of competency requirements. There is a growing believe that it is simply impossible to improve a person's performance until specific competencies required for satisfactory or superior performance are identified. It is only after these competencies are identified that staff could be selected. Some new recruits may require skill or knowledge enhancement to be able to perform optimally. Research is needed to identify the impact of clearly defined competency requirements on staff performance, if any. This is an indication that healthcare workforce competence had a statistically significant effect on healthcare quality service delivery in the public service.

8.3 Conclusion of the Study

Conclusions of this study were made based on the objectives and guided by the themes of the study. Based on the first objective, to a great extent resources are required, (physical, Financial and human facilities) to support Quality service delivery in healthcare. To a great extent the financial systems and procedures established by the organization supported Quality service delivery in healthcare. Further, to a great extent the county maintained financial management systems to ensure proper utilization of funds, accountability, financial monitoring and efficient reporting, all geared towards Quality service delivery in healthcare; and resources got allocated optimally for the sake of minimizing production costs and creating added value for the outputs. Finally, however, IT was not fully utilized for standardization of operations and lowering cost for Effective County based healthcare quality service delivery. It can therefore be concluded that resource allocation had to a significant extent helped in the healthcare quality service delivery in Busia County.

Based on the second objective, employees needed to be supervised closely, or they were not likely to do their work. Also, employees wanted to be a part of the decision-making process and in complex situations, leaders should let subordinates work problems out on their own. Moreover, most employees felt secure about their work and did not need direction. Often, the leader was the chief judge of the achievements of the members of the group, and it was the leader's job to help subordinates find their "passion." Furthermore, effective leaders gave orders and clarified procedures. It can therefore be concluded that health leadership was significantly ineffective in influencing healthcare quality service delivery in Busia County.

Based on the third objective, the County had an organization's structure that didn't support healthcare quality service delivery. Also, the organization's structure was aligned according to the central government and the structure focused on centrality in reporting. There had been change of organizational structure to support healthcare quality service delivery and the County constantly embraced change. The organization's structure used a Flat line policy and structure and had a rigid bureaucracy. However, structural changes were not communicated to all employees. Finally, the organization's structure had not been effective in enhancing healthcare quality service delivery. It can therefore be concluded that organizational structure was ineffective in influencing healthcare quality service delivery in Busia County.

Based on the first conclusion, there was a Healthcare workforce competence gap based on the negative scores. However this did not have a direct impact on their performance since majority received formal training. Lack of in-service training, inadequate remuneration and delayed promotions contributed to negligence in the performance of some duties. It can therefore be concluded that there was an effective Healthcare workforce competence that could improve healthcare quality service delivery in Busia County but this could not be realized due to a demotivated workforce.

8.4 Recommendations of the Study

Based on the objectives and conclusions, this study recommends that;

The County Government management should ensure that they engage in proactive and effective resource allocation mechanisms (financing, technology and human resource) to improve provision of quality healthcare services. The allocations should be deliberate with significant resources given to critical service delivery areas.

The National Government should ensure that resource allocation to County governments should be disbursed on time to ensure effective service delivery in the devolved units.

The National Government through the Ministry of Devolution and Planning should improve on its devolution policy to further fortify health provision in the counties.

8.5 Suggestions for Research

This study proposes that further research be done in the following areas:

1. Further research should be done on barriers to strategy formulation process and how they impact on healthcare quality service delivery in the counties.
2. The impact of the universal healthcare on devolved healthcare quality service delivery.
3. Research to examine how competence of healthcare workforce influences healthcare quality service delivery.

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APPENDICES

Appendix I: Request Letter

Dear Respondent,

I am Chemei George, Moi University Student pursuing Master of Arts Degree in Public Policy and Administration. As a requirement, I am carrying out research titled; An Assessment of the Effect of Devolution on Healthcare Quality Service Delivery in Busia County, Kenya. I am writing this letter to request you to be part of my research by answering the questionnaire to the best of your ability. The information you provide is purely for academic purposes and will be treated with confidentiality.

Kind Regards

Chemei George

SASS/PGPA/04/13

Appendix II: Questionnaire

Part A: General Information

Instruction: Please tick and/or fill the blank space appropriately

1. Gender

   Male ( ) Female ( )

2. Age bracket

   Below25 ( ) 26-35 ( ) 36-45 ( )

   46-55 ( ) 56-65 ( ) Above 66 ( )

3. Highest level of education

   O-Level ( ) A-Level ( ) Bachelor's degree ( )

   Master's degree ( ) Doctoral degree ( ) Others ( )

4. Level of experience

   Less than 10 years ( ) 11-20 years ( ) Above 21 years ( )

Section B: Objective guided questions

5. What is your understanding of the term **'devolution'**?

   ……

   ……

   ……

   ……

6. Was the idea of devolving the healthcare sector appropriate?

   Yes ( ) No ( )

   Explain your answer .....

   .....

   .....

7. Please answer the questions using Linkert scale below where; ***SD=Strongly Disagree (1), S=Disagree (2), N=Neutral (3), A=Agree (4), SA=Strongly Agree (5)***

Dimension	**Item**	**Rate**
Tangibility	Excellent Busia County Health Institutions has modern looking equipment	
	Excellent Busia County Health Institutions physical facilities are visually appealing	
	Excellent Busia County Health Institutions reception desk employees are neat in appearance	
	An excellent Busia County Health Institutions receipts, cheques and similar materials are visually appealing	
Reliability	When an excellent Busia County Health Institutions promises to do something by a certain time, it does so	
	When customers have problems employees in an excellent Busia County Health Institutions will be sympathetic and reassuring	
	An excellent Busia County Health Institutions performs the service right the first time	
	An excellent Busia County Health Institutions provides its services at the time it promises to do so	
	An excellent Busia County Health Institutions insists on error-free records	
Responsiveness	Employees in an excellent Busia County Health Institutions tell exactly when the services will be performed	
	Employees in an excellent Busia County Health Institutions give prompt services	
	Employees in an excellent Busia County Health Institutions are always willing to help clients	
	Employees in an excellent Busia County Health Institutions are never too busy to respond to Clients' questions	
Assurance	Employees in an excellent Busia County Health Institutions instill confidence in clients	

	Employees in an excellent Busia County Health Institutions always respect clients	
	Employees in an excellent Busia County Health Institutions have necessary knowledge to answer clients questions	
Empathy	An excellent Busia County Health Institutions gives clients individual attention	
	An excellent Busia County Health Institutions has working hours suitable for all clients	
	An excellent Busia County Health Institutions has client's best interest at heart	
	The employees of an excellent Busia County Health Institutions understand supplier specific Needs	

8. Do you know of actors involved in devolution of healthcare sector in Busia County?

   Yes ( ) No ( )

   If Yes, please state some of the actors.....

9. Please explain on the roles of actors involved in devolution of healthcare sector in Busia County?

   ……

   ……

10. Kindly provide your rating of the influence of resource allocation on healthcare quality service delivery in Busia County. Where; ***VGE=Very Great Extent, GE=Great Extent, M=Medium, LE=Less Extent, and NA=Not Agree***

STATEMENTS	**VGE**	**GE**	**M**	**LE**	**NA**
To what extent does the availability of resources required, (physical Financial and human facilities) support the Quality service delivery in healthcare?					
To what extent do the financial systems and procedures established by the organization support Quality service delivery in healthcare?					
To what extent does the county maintain financial management systems to ensure proper utilization of funds, accountability, financial monitoring and efficient reporting, all geared towards Quality service delivery in healthcare?					
To what extent do resources get allocated optimally for the sake of minimizing production costs and creating added value for the outputs?					
To what extent does IT get utilized for standardization of operations and lowering cost for effective County based healthcare quality service delivery?					

11. What is your view on the devolution of healthcare sector in Busia County, Kenya?

.....

.....

12. Which of the following actors do you know to be involved in healthcare sector?

Stated Actors	**Tick appropriately**
Ministry of Health	
Private Sector	
Public Sector	
Individuals (Volunteers)	
Development Partners	

13. There are several influences of Health leadership on Quality service delivery in health care. Please rate the following where;***SA=Strongly Agree, A=Agree,N=Neutral, S=Disagree,, SD=Strongly Disagree***

STATEMENTS	**SA**	**A**	**N**	**D**	**SD**
Employees need to be supervised closely, or they are not likely to do their work.					
Employees want to be a part of the decision-making process					
In complex situations, leaders should let subordinates work problems out on their own					
It is fair to say that most employees in the general population are lazy.					
Providing guidance with pressure is the key to being a good leader.					
As a rule, employees must be given rewards or punishments in order to motivate them to achieve organizational objectives.					
Most workers want frequent and supportive communication from their leaders.					
Most employees feel insecure about their work and need direction.					
The leader is the chief judge of the achievements of the members of the group.					
It is the leader's job to help subordinates find their "passion."					
Effective leaders give orders and clarify procedures.					

14. The effects of Organization Structure on Quality service delivery in healthcare vary. What is your view based on the questions below?

STATEMENTS	**SA**	**A**	**N**	**D**	**SD**
The County has an Organization's structure that supports healthcare quality service delivery					
Organization's structure is not aligned according to the central government					
Our organization's structure focuses on Centrality in reporting					
There has been change of organizational structure to support healthcare quality service delivery					
Our County constantly embraces change					
Our organization's structure uses a Flat line policy and structure					
We have a rigid bureaucracy					
We have a Straight line structure without too many levels of hierarchy					
Our organization's structure had not been effective in enhancing healthcare quality service delivery					

15. In your own opinion, to what extent is the implementation of devolved healthcare sector in Busia County?

    .....

    .....

    .....

16. In your opinion, which management strategies should be used to ensure efficient healthcare service provision in Busia County?

    .....

    .....

    .....

17. How can you advice the government and county executive to ensure successful transfer of healthcare functions to the Counties?

.....

.....

.....

Thank you

Appendix III: Interview Schedule

1. What is your age bracket?

   Below25 ( ) 26-35 ( ) 36-45 ( ) 46-55 ( ) 56-65 ( ) Above 66 ( )

2. What is your highest level of education?

   O-Level ( ) A-Level ( ) Bachelor's degree ( )

   Master's degree ( ) Doctoral degree ( ) Others ( )

3. How long have you been in service?

   Less than 10 years ( ) 11-20 years ( ) Above 21 years ( )

4. What is your understanding of the term **'devolution'**?
5. What is your view on the devolution of healthcare sector in Busia County, Kenya?
6. What is your view in line with implementation of devolved healthcare in Busia County?
7. In your own opinion, to what extent is the implementation of devolved healthcare sector done in Busia County?
8. Please explain on the roles and effectiveness of actors involved in devolution of healthcare sector in Busia County?
9. How do you view the quality of healthcare service delivery in Busia County after healthcare services were devolved?
10. How can you rate the efficiency of healthcare service management after devolution in Busia County?
11. In your opinion, which management strategies should be used to ensure efficient healthcare service provision in Busia County?
12. How has devolution on healthcare affected service delivery in Busia County?
13. How can you advice the government and county executive to ensure successful transfer of healthcare functions to the Counties?

Thank you

Appendix IV: Map Showing Busia County

Appendix 6: Healthcare Facilities in Busia County.

S/N0	FACILITY CATEGORY	NUMBER OF FACILITIES
1	BUSIA COUNTY REFERRAL HOSPITAL	1
2	SUB COUNTY HOSPITAL	6
3	HEALTH CENTERS	12
4	DISPENSARIES	49
5	MEDICAL CLINICS	10
6	NURSING HOMES	3
TOTAL		**81**

Source: CIDP, (2018)

Appendix V: Busia County Budgetary Allocation for Department of Health

DEPARTMENT OF HEALTH AND SANITATION COUNTY GOVERNMENT OF BUSIA

DEPARTMENTAL BUDGETARY ALLOCATION FROM 2013-2019		
NO.	FINANCIAL YEAR (FY)	BUDGETARY ALLOCATION
1.	FY 2013/2014	893,030,294
2.	FY 2014/2015	1,501,220,941
3.	FY 2015/2016	1,558,838,378
4.	FY 2016/2017	1,708,388,557
5.	FY 2017/2018	1,838,370,959
6.	FY 2018/2019	1,979,519,340
7.	FY 2019/2020	2,540,718,169
	TOTAL	**12,020,086,638**

Source: County Government of Busia, (2019)

Appendix VI: Authorization Letter from Moi University

MOI UNIVERSITY
(ISO 9001:2008 CERTIFIED)
SCHOOL OF ARTS AND SOCIAL SCIENCES
DEPARTMENT OF HISTORY, POLITICAL SCIENCE & PUBLIC ADMINISTRATION

Tel: (053) 43620
Fax No. (053) 43047
Telex No. MOI VARSITY 35047

P.o Box 3900
Eldoret
Kenya

5th May 2017

MINISTRY OF HIGHER EDUCATION, SCIENCE AND TECHNOLOGY
NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY
P.O. BOX 30623-00100
NAIROBI

REF: CHEMEI GEORGE-SASS/PGPA/04/13

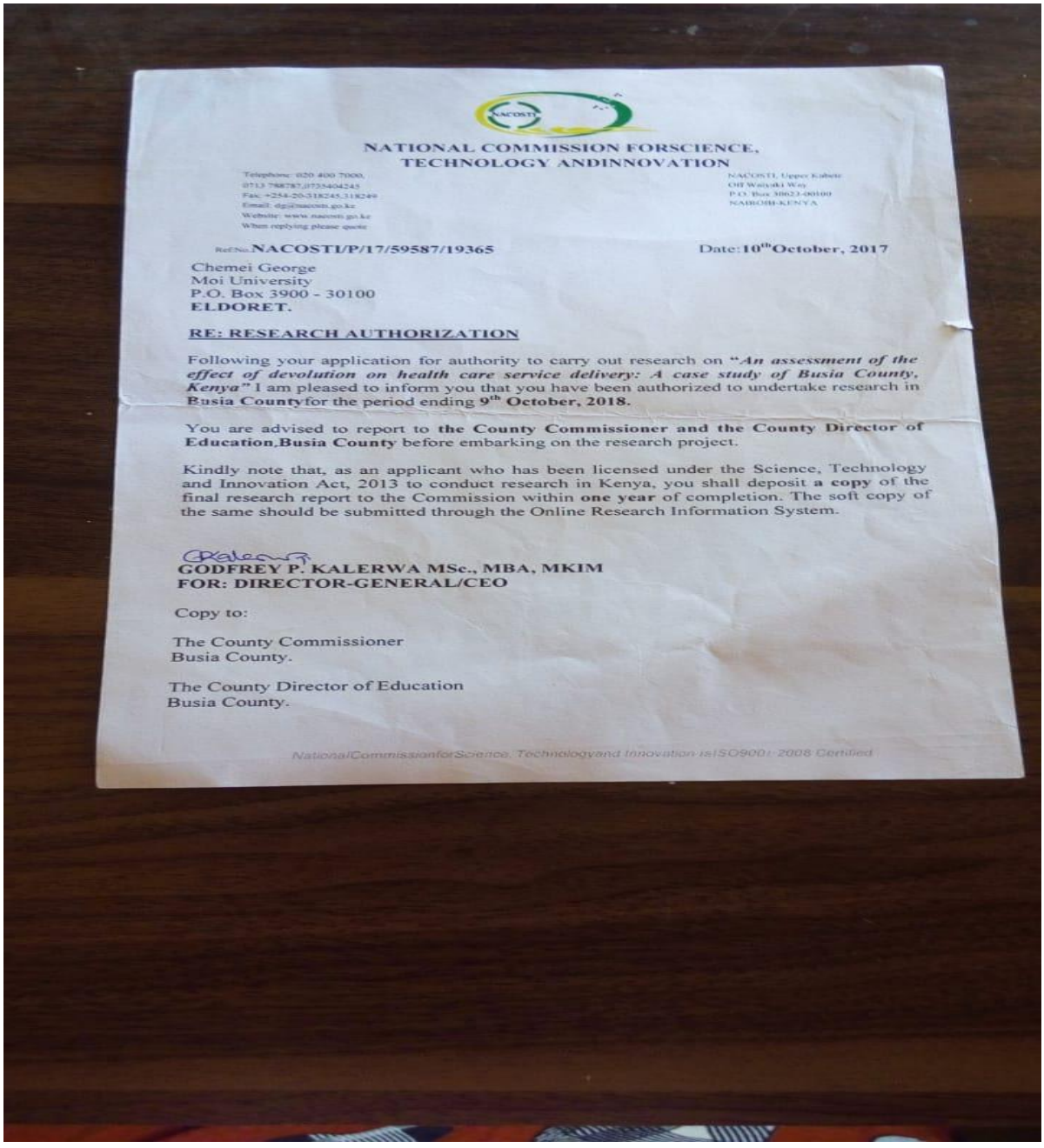
This is to confirm that the above named is a student in the School of Arts and Social Sciences, Department of History, Political Science and Public Administration pursuing a Masters Degree in Public Administration and Policy. He has successfully completed his coursework and defended his proposal titled: **"An Assessment of the Effect of Devolution on Health Care Service Delivery: A Case Study of Busia County, Kenya"**. He is now allowed to collect research permit in order to collect data in the field.

Any assistance given to him will be highly appreciated.

DEPT. OF HISTORY, POLITICAL SCIENCE & PUBLIC ADMINISTRATION
05 MAY 2017
MOI UNIVERSITY
P. O. Box 3900, ELDORET

Dr. Ken Oluoch
Head, Department of History Political Science and Public Administration

Appendix VII: authorization Letter from NACCOSTI



NATIONAL COMMISSION FORSCIENCE,
TECHNOLOGY ANDINNOVATION

Telephone: 020 400 7000,
0713 788787,0735404245
Fax: +254-20-318245,318249
Email: dg@nacosti.go.ke
Website: www.nacosti.go.ke
When replying please quote

NACOSTI, Upper Kabete
Off Waiyaki Way
P.O. Box 30623-00100
NAIROBI-KENYA

Ref No. NACOSTI/P/17/59587/19365 Date: 10th October, 2017

Chemei George
Moi University
P.O. Box 3900 - 30100
ELDORET.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"An assessment of the effect of devolution on health care service delivery: A case study of Busia County, Kenya"*** I am pleased to inform you that you have been authorized to undertake research in **Busia County** for the period ending **9th October, 2018.**

You are advised to report to **the County Commissioner and the County Director of Education,Busia County** before embarking on the research project.

Kindly note that, as an applicant who has been licensed under the Science, Technology and Innovation Act, 2013 to conduct research in Kenya, you shall deposit **a copy** of the final research report to the Commission within **one year** of completion. The soft copy of the same should be submitted through the Online Research Information System.

GODFREY P. KALERWA MSc., MBA, MKIM
FOR: DIRECTOR-GENERAL/CEO

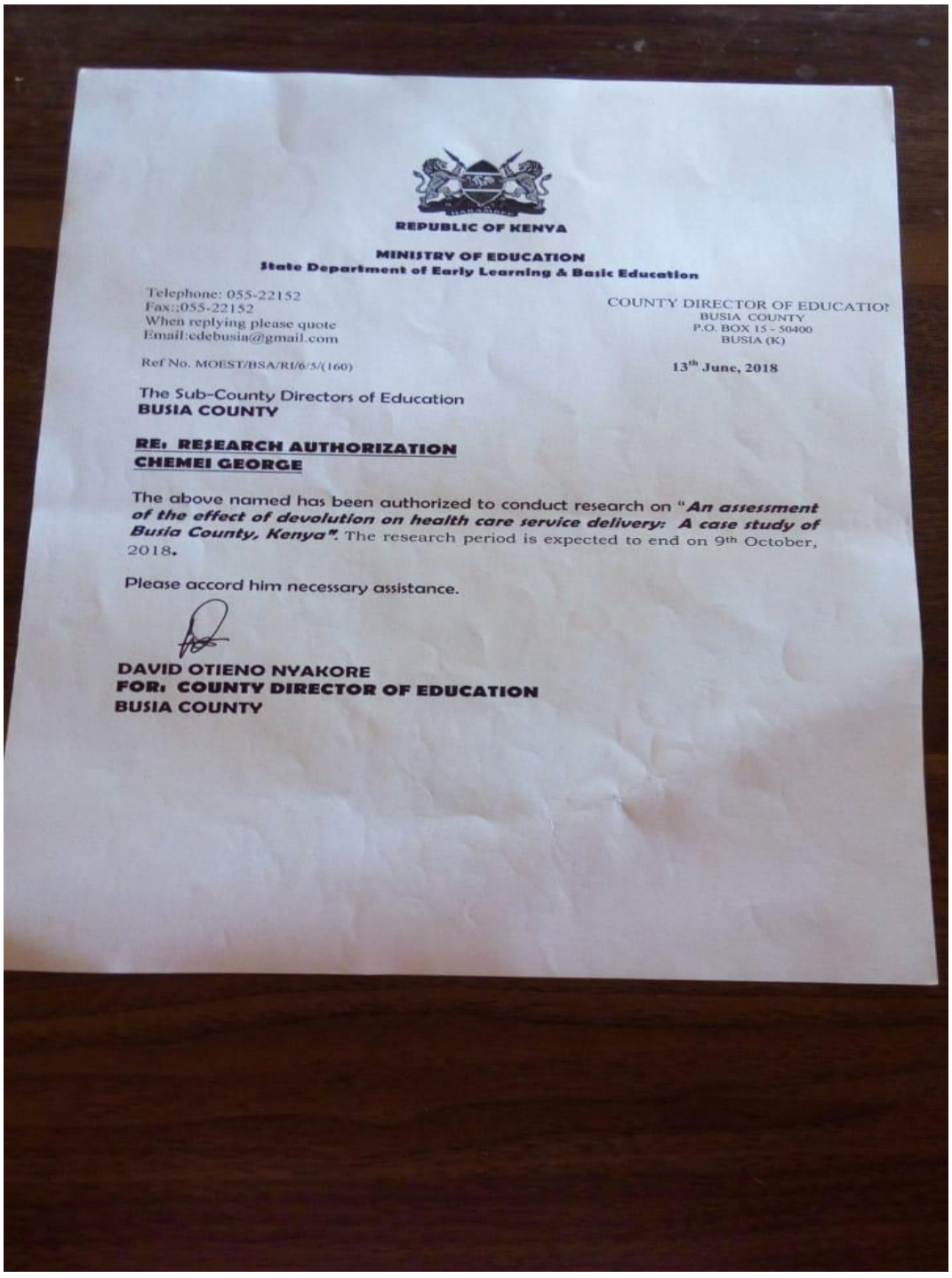
Copy to:

The County Commissioner
Busia County.

The County Director of Education
Busia County.

National Commission for Science, Technology and Innovation is ISO9001: 2008 Certified

Appendix VIII: Authorization Letter from County Director of Education



REPUBLIC OF KENYA

MINISTRY OF EDUCATION
State Department of Early Learning & Basic Education

Telephone: 055-22152
Fax::055-22152
When replying please quote
Email:cdebusia@gmail.com

COUNTY DIRECTOR OF EDUCATION
BUSIA COUNTY
P.O. BOX 15 - 50400
BUSIA (K)

Ref No. MOEST/BSA/RI/6/5/(160)

13th June, 2018

The Sub-County Directors of Education
BUSIA COUNTY

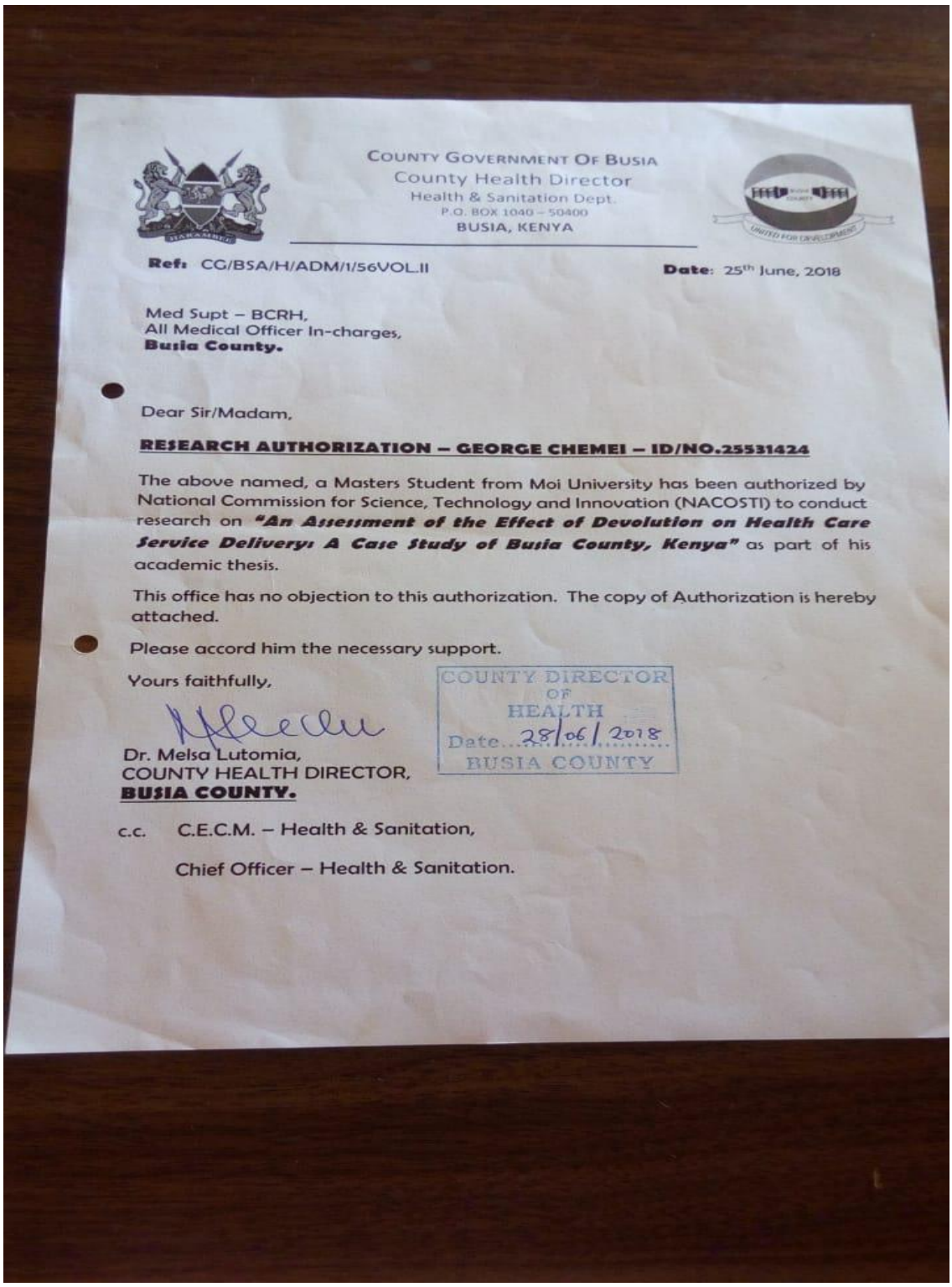
RE: RESEARCH AUTHORIZATION
CHEMEI GEORGE

The above named has been authorized to conduct research on "***An assessment of the effect of devolution on health care service delivery: A case study of Busia County, Kenya***". The research period is expected to end on 9th October, 2018.

Please accord him necessary assistance.

DAVID OTIENO NYAKORE
FOR: COUNTY DIRECTOR OF EDUCATION
BUSIA COUNTY

Appendix XV: Authorization Letter from the County Government



COUNTY GOVERNMENT OF BUSIA
County Health Director
Health & Sanitation Dept.
P.O. BOX 1040 – 50400
BUSIA, KENYA

Ref: CG/BSA/H/ADM/1/56VOL.II

Date: 25th June, 2018

Med Supt – BCRH,
All Medical Officer In-charges,
Busia County.

Dear Sir/Madam,

RESEARCH AUTHORIZATION – GEORGE CHEMEI – ID/NO.25531424

The above named, a Masters Student from Moi University has been authorized by National Commission for Science, Technology and Innovation (NACOSTI) to conduct research on ***"An Assessment of the Effect of Devolution on Health Care Service Delivery: A Case Study of Busia County, Kenya"*** as part of his academic thesis.

This office has no objection to this authorization. The copy of Authorization is hereby attached.

Please accord him the necessary support.

Yours faithfully,

COUNTY DIRECTOR OF HEALTH
Date 28/06/2018
BUSIA COUNTY

Dr. Melsa Lutomia,
COUNTY HEALTH DIRECTOR,
BUSIA COUNTY.

c.c. C.E.C.M. – Health & Sanitation,

Chief Officer – Health & Sanitation.